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ABSTRACT

This study examines patterns of service utilization among Hispanics, Whites, and Blacks living in the South Bronx, New York City. Surveyed were 381 respondents on their use of the following types of services: (1) mental health services; (2) services for female heads of families; (3) services for disabled persons; and (4) services for elderly persons. The study also assesses the needs that give rise to service utilization, and reviews the research and theory pertaining to Hispanic underutilization of services. Findings are presented in the following areas: (1) patterns of use of services; (2) knowledge of and satisfaction with services; and (3) factors associated with use of services. In general, substantial proportions of Hispanics, Blacks, and Whites who live in inner-city areas like the one surveyed are not able to take advantage of the mental health and social services that they report they need. Policy recommendations are offered. Data are presented on 27 tables and figures. Seven lists comprising 105 references are included. An appendix assesses the reliability of the Demoralization Scale, one of the survey instruments used in the study. (BJV)

Hispanic Research Center
Fordham University

Hispanics and Human Services: Help-Seeking in the Inner City

Orlando Rodriguez

Monograph No. 14

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PREFACE

The study presented here provides a much needed examination of patterns of service utilization among three groups — Hispanics, whites, and blacks — living in the South Bronx, an area that has become a national symbol of urban decay. It goes beyond the usual examination of mental health service utilization to consider the use of other services as well by persons experiencing specific needs.

Three features make this study stand out from other utilization research. First, it has a comparative framework which expands our understanding of utilization across the spectrum of Hispanic, black and white groups. Research focusing upon one group incurs the risk of implicitly attributing unique features to that group which may in fact be shared by other groups. The value of comparative analysis between groups is that it enables the delineation of intergroup similarities and differences and allows tests of the generalizability of hypotheses across groups.

The second feature which commends this study is its assessment of the needs which give rise to utilization. Typically, the determination of clients' over- and underutilization of services is based upon the simplistic procedure of comparing the proportion of users of a particular service who are members of a specific ethnic group with that group's proportionate size in the population of the relevant catchment area. When the first proportion is smaller than the second proportion, the group is said to underutilize services; when the first proportion is larger than the second it is said to overutilize. This procedure can lead to misconceptions in research and misformulation of policies because the magnitude of the clients' need is left undetermined. The study presented here overcomes this problem because it has independent measures of the need factor giving rise to service utilization.

The concept of need leads to the third contribution the study makes: it is embedded in an explicitly articulated theoretical orientation. Briefly, the orientation argues that persons with high needs for services are led to use or not to use a service according to whether or not they have alternative resources in their associations with other persons and according to their experiences with barriers to utilization. The study makes it abundantly clear that its test of barrier theory includes only client variables and not variables reflecting the institutional character of the service organization. A comprehensive test of barrier theory would require both kinds of variables. But this the study does not do and does not presume to have done. In this respect, it bears a complementary relationship to a plethora of research which demonstrates that institutional barriers keep clients in need from making use of services.

This monograph is the fourteenth in a series published by the Hispanic Research Center to stimulate interest in Hispanic concerns.

The Center was established at Fordham University in 1977, under a grant from the National Institute of Mental Health, to work toward five major objectives (1) to develop and conduct policy-relevant epidemiological-clinical services research on processes relevant to Hispanic mental health, (2) to increase the small pool of scholars trained in Hispanic mental health research and to upgrade their research skills through the provision of apprenticeship training and other mechanisms; (3) to provide technical assistance to organizations and individuals interested in the mental health problems of Hispanics; (4) to disseminate information on issues relevant to Hispanic mental health; and (5) to develop a research environment for scholars from the mental health disciplines

Lloyd H. Rogler
Director, Hispanic Research Center
Fordham University
January 1987

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The research described in this monograph was conducted under a subcontract with Fordham-Tremont Community Mental Health Center's (CHMC) Hispanic Access Project (HAP), one of eight nationwide demonstration projects to develop innovative service delivery models for Hispanic populations funded by the Office of Human Development Services (OHDS), U.S. Department of Health and Human Services. HAP was unique in that it proposed to conduct basic research on utilization of human services in conjunction with its service delivery. Because the proposed research involved long-term data gathering and analysis, the research and service delivery components evolved in separate streams, without the opportunity to apply the research findings to the Hispanic Access interventions. Nevertheless, the project was instrumental in initiating another collaborative relationship between Fordham-Tremont CMHC and the Hispanic Research Center (HRC): Project COPA, a demonstration project funded by New York State's Office of Mental Health to enhance clinical services for chronically mentally ill Hispanics in the South Bronx. Using the data gathered in HAP, the HRC provided Fordham-Tremont with empirically-based information on barriers to use of mental health services by psychologically distressed Hispanics in the South Bronx. This information was utilized by Project COPA to design interventions to address these barriers. Subsequently, the HRC monitored project interventions to assess the impact of the interventions.

The organic relationship between research and practice evidenced by these demonstration projects is due in great part to the farsightedness and receptivity to research of Fordham-Tremont's administrators and professional staff. HAP provided a setting supportive of research and an opportunity to learn about the difficult problems faced by professionals who serve inner-city populations. As one of the staff

members involved in this collaborative relationship, I am pleased to acknowledge the support of Gemma Hessian and Ann Burgunder, former Director and Deputy Director respectively, and of Dr. Mildred Mesch Allen, current Director of Fordham-Tremont CMHC; I gratefully acknowledge the contributions to the research of Frances Lorenzi, the first Director of HAP and currently Deputy Director of Fordham-Tremont CMHC; Alma Gomez, HAP's subsequent Director and currently Fordham-Tremont's Director of Consultation and Education; and Dr. Aida Burnett, co-Director of HAP. I am also grateful to Dr. Miguel Torrado for his contributions to the research. Dr. Torrado, currently Director of OHDS for Region II, was OHDS Project Officer for the Hispanic Access Demonstration Project, and subsequently was Director of Consultation and Education at Fordham-Tremont CMHC. These colleagues were extremely helpful in formulating the programmatic issues that the research addressed, in contributing to the research design plan, and in commenting on the implications of findings as the analysis progressed.

The survey that provided the data for this monograph involved face-to-face administration of a complex structured questionnaire to a sample of residents of the Fordham-Tremont CMHC catchment area. Successful completion of this task would not have been possible without the commitment and resourcefulness of the survey field team. I am grateful to William Burger, HRC Research Assistant, for helping to plan the sampling and field work, for guiding the field team through many difficult moments, and for his subsequent assistance in data analysis. My thanks to Dolores Alvarado, the late Osvaldo Barrera, Ana Brito, Carmen Carballo, Cesar Mieses, Dr. Ronald Morris, Ramona Piñeiro, . Carmen Rivera, and Gladys Venegas. Ramona Piñeiro, Osvaldo arrera, and Ronald Morris were especially helpful in persuading respondents who were reluctant to participate. In using part of the data for her Ph.D. thesis in Clinical Psychology, Dr. Rivera helped to select many of the mental health-relevant measures used in the survey and contributed to the interviewing effort. The field effort faced difficulties in reaching residents in some neighborhoods and in finding sufficient numbers of elderly persons, a group of interest to the research. I am grateful to Father David Casella, pastor of St. Thomas Aquinas R.C. Church and President of the Board of Fordham-Tremont CMHC; Father Robert Trainer of Our Lady of Angels R.C. Church; Msgr. John McCarthy of St. Brendan's R.C. Church; and George Morfogen, Director of the Hodson Senior Citizen Center, for providing access to respondents and to their facilities to conduct interviews.

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1

HISPANIC UNDERUTILIZATION OF SERVICES: RESEARCH AND THEORY

This study addresses an issue of concern to Hispanic communities in the United States: the utilization of mental health and social services by Hispanics. The study investigates the extent to which Hispanic residents in a major poverty area of the Bronx underutilize or overutilize selected mental health and social services in relation to their needs and in comparison to black and white groups. The study then proceeds to weigh the individual and joint influences of variables underlying the utilization of different services by Hispanics and other residents of the area.

Proponents of the underutilization thesis assert that Hispanics, in proportion to their numbers in the population, are underrepresented among users of health, mental health, and social services.[1] At the outset, the concept of "underutilization" needs to be clarified. Underutilization may imply that people need and want a service, but do not use it because of barriers which prevent them from seeking out and profiting from the service; for example, lack of knowledge about available services or discrimination by agency personnel. Underutilization may also imply that people do not use services because they rely on alternative, non-institutional help providers. Each implication of underutilization has a divergent impact on policy formulations. If Hispanics underutilize formal agency services because of barriers, vigorous public intervention would be needed to reduce or eliminate these barriers. If, on the other hand, Hispanics rely on alternatives to formal organizations for help, and if alternative mechanisms such as the family can be shown to be truly helpful, this would suggest that the official agency system intertwine its efforts with those of informal helpers so that these "natural support systems"[2] may enhance their help-giving function. By determining if and how Hispanics in an area of the South Bronx underutilize [illegible] and mental health services, we hope to provide public and private entities with empirically grounded recommendations about the type of interventions that will most effectively improve the access of Hispanics to mental health and social services.

In this chapter, we provide an overview of the literature on the underutilization of different types of services by Hispanics. Subsequent chapters review this literature in greater detail. We will develop from this review the methodological and theoretical considerations that guide our study.

The Evidence of Hispanic Underutilization of Services

Research has identified the utilization of social and health services as one of the most crucial policy areas affecting Hispanic life in the United States. These studies point to the underutilization of services as an ever-present fact in Hispanic life, but they differ substantially in attributing causes to the observed underutilization patterns. Although most of the existing studies are in the areas of health and mental health services, studies of other services seem to point to a similar pattern.

Generally, utilization research circumscribes its theory and findings within a specific service area, rarely addressing findings and interpretations of researchers in other service areas. By reviewing utilization across a broad spectrum, gaps in one service area may be informed by findings in other areas. Thus, one objective of this review is to identify areas of covergence in approaches, findings, and interpretations of Hispanic utilization across a range of social and health services. Comparatively more is known about Hispanic utilization patterns in health and mental health than in other types of services. The bulk of the evidence buttresses the commonly held assumption that Hispanics underutilize services, but gaps in research areas and methodological deficiencies in present research leave much to be discovered.

Several national surveys of admissions to psychiatric facilities indicate Hispanic underutilization of mental health facilities. These studies have found that Hispanics underutilize public outpatient psychiatric facilities and private psychiatric facilities, but overutilize inpatient facilities.[3] Contradictory evidence on utilization of inpatient facilities is found in Bachrach's study, also based on national admissions data.[4] Studies of Mexican American populations generally support the notion of underutilization of facilities,[5] but the evidence for Puerto Ricans is mixed (see Chapter 3 for a review of this evidence). Utilization patterns among other Hispanic minorities are simply not known.

Several major studies document underutilization of health services among Hispanics. With respect to Mexican Americans in the Southwest, Anderson et al.[6] have reviewed previous studies showing substantial underutilization and present data showing that — even when adjusted for medical need — Mexican Americans are less likely to visit doctors, to have preventive health examinations, or to see dentists, but are as likely to be admitted to hospitals as non-Mexican Americans. Similar findings are reported for Mexican Americans residing in California.[7] Studies of Puerto Ricans in New York also document underutilization of medical services.[8] Among these, Alers' analysis of

New York City health data dramatically underscores Hispanic underutilization of health facilities, showing, for example, that Puerto Ricans constitute the highest proportion of self-pay patients and, paradoxically, the highest proportion of low-income patients in city hospitals. With respect to Cubans, Dominicans, and other Hispanic minorities, data are virtually non-existent.

A consistent finding in these studies is the Hispanics' tendency to underutilize preventive as opposed to emergency or primary care facilities. This tendency is somewhat analogous to the tendency, found in one National Institute of Mental Health (NIMH) study,[9] of Hispanics to overutilize inpatient psychiatric services, which are more oriented toward the resolution of crises and severe symptoms, and to underutilize outpatient services, which serve milder cases.

In contrast to health and mental health studies, research on Hispanic patterns of utilization of social services is rare. Social services include a mix of services which fall under the mandates of various government agencies, for example, day care, Head Start, vocational rehabilitation, services for the elderly, job training, and adult education. Cash grants under the various income maintenance and benefits progams may also be included among social services. In Chapter 4 we review the few studies of Hispanic utilization of service for female heads of family and children.

Studies of utilization of social services by Hispanics present a mixed picture, providing evidence for overutilization of some services and underutilization of others. For example, the Office of Human Development Services (OHDS), U.S. Department of Health and Human Services, conducted a survey of Hispanic participation rates in OHDS programs, based on data supplied by state OHDS program officials. Participation was measured by means of a simple parity ratio: the percentage of Hispanic participants in a given state's program divided by the percentage of Hispanics in the state's population in need of services. Overall, the study found that Hispanics represent 13.3 percent of participants in OHDS programs and 17.1 percent of those who are in need of services, for a parity participation rate of 77.9 percent. Parity percentages were particularly low in vocational rehabilitation, programs for the economically disadvantaged, and other programs for children, youth, and families, while parity was over 100 percent for programs for the elderly.[10] Our research review found more studies focusing on use of services by the elderly, but fewer focusing on the Hispanic elderly. In Chapter 5 we review these studies, which show that minority elderly are less likely than white elderly to receive services.[11]

Some conclusions may be derived from this brief review of studies. First, we lack systematic knowledge about patterns of utilization of services among the different Hispanic minorities. Even in the areas of health and mental health services, existing research is hampered by divergent definitions of utilization and the restriction of studies to

Mexican Americans and Puerto Ricans. Second, Hispanic subgroups appear to differ with respect to the types of service that they tend to underutilize, but it is not clear what these differences are, or whether they apply across the board for all types of services. The literature also suggests that Hispanics tend to overutilize crisis-oriented services and to underutilize preventive services. Given this information, little is known about those factors associated with utilization. For example, do Hispanics underutilize services because of the particular characteristics of Hispanic culture, because of characteristics they share with other minorities (low income and low education), or because of barriers to use of services imposed by service agencies and the system of social welfare? If there are differences in utilization among Hispanics of different national origin, do these differences reflect subcultural differences between Hispanic subgroups, the particular institutional barriers found in different geographical and service areas, or differences in actual needs of these services among Hispanic subgroups? Because there exist several and competing explanations for underutilization, we discuss below the conceptual framework[12] to guide our research on the utilization of services.

A Conceptual Framework for the Study of Hispanic Underutilization

This study attempts to discover the extent to which — and the reasons why — Hispanic residents of a South Bronx area underutilize or overutilize a variety of mental health and social services. Our research design includes measures of needs for services; a comparative examination of Hispanic utilization against the experiences of other ethnic groups; and the incorporation of the major competing perspectives on underutilization. Although it is important for studies to examine utilization patterns within the different Hispanic groups because there may be substantial differences among them, we did not do so, since most Hispanic residents in our study area are Puerto Rican. Since our sample, however, includes Hispanics of other origins, we follow the convention of using the generic term Hispanic.

If utilization rates are to have policy-relevant meaning, they need to be measured against the true extent of need among a given population. This point may be illustrated with the example of differences in mental health facility utilization rates among Puerto Ricans, blacks, and whites. As will be shown in Chapter 3, Puerto Ricans have rates of admissions to mental health facilities lower than those of blacks and whites. At the same time, Puerto Ricans have higher rates of mental illness symptoms than other groups.[13] This suggests that Puerto Ricans may underutilize mental health facilities more than other groups with lower mental illness rates. Thus, utilization rates should be measured against a needs baseline. To date, studies of mental health services utilization among Hispanics have not included measures of psychological distress as used in epidemiological studies. Measures of need

appear more frequently — but not always — in health utilization studies.[14] In our study we measured need by directly asking the respondent if any member of the household needed any of the services relevant to that household. In the case of mental health services, we also included a mental health scale to derive an objective measure of need for those services. Chapter 2 discusses the measures of need, utilization, and of variables used to explain utilization.

Hispanic service utilization rates are difficult to interpret without reference to the experiences of other ethnic groups. Unfortunately, interethnic comparative studies of utilization are few in number. This comparative deficit is particularly glaring in the studies' inability to ascribe causal weight to the factor of minority status. If Hispanics underutilize a given service, is this due to Hispanic subcultural characteristics or to some attribute of minority status such as poverty? Inclusion of whites in the research would control for minority status, while inclusion of blacks would control for subcultural differences between two minority groups, blacks and Hispanics. Our study employs a comparative perspective and provides information on the service needs and experiences of Hispanics, blacks, and whites in an area of the South Bronx.

The research literature has identified several factors which are possibly related to the underutilization of services. These may be subsumed under the categories of subcultural factors — characteristics of Hispanic social life and subcultural values which make professional services unattractive to Hispanics — and institutional factors — characteristics of agencies and of the social welfare system which discourage Hispanics from using these services. For the most part, these factors have been brought out in studies of health and mental health services utilization, and our review reflects this bias in the literature. In our discussion below, we begin with the simple assumption that these factors are applicable to the utilization of all types of services.

Since the term "factor" may convey a specific technical meaning to some readers, it may be useful to explain how the term will be used here. We use the term "factor" to denote a group of variables which measure different aspects of an explanatory concept. For example, we refer below to the person's length of residence in the United States, the person's age at the time of permanent settlement in the U.S., and measures of assimilation to American life as variables related to explanations of utilization focusing upon the factor of subcultural barriers. By the same token, we follow the convention of some types of social science discourse by using the term "model" as a shorthand description for the analytical approach of the study. In this sense our model can be described as an attempt to determine the applicability of competing explanations of underutilization by examining in multiple regression analysis the influences of variables indicative of these explanations.

Consideration of the supposed influences of subcultural and institutional factors leads us to use two competing explanations of underutilization: alternative resources and barrier theory. Alternative resource theory posits that a number of factors pertinent to the primary group structure of Hispanic life may provide alternatives to reliance on services. Among these are the Hispanic family and *compadrazgo* systems, the intimate network of neighbors, friends, and acquaintances, and the indigenous folk healing institutions. All these structures are seen as emotionally supportive and help-giving mechanisms that Hispanics may rely on *instead* of going to burreaucratically organized agencies.

Several studies of Mexican American and Puerto Rican mental health problems assert that each group relies on immediate family and extended kin and on friends and neighbors for support with emotional problems, although these studies disagree on the relative importance of family and friends as sources of support.[15] On the other hand, studies of Puerto Ricans in the island and in New York City have been unable to verify the importance of the *compadrazgo* system as a help-giving system, suggesting that modernization in Puerto Rico and acculturation among Puerto Ricans in New York have made inroads into the traditional culture.[16]

Considerations of the influence of family and friends may be set within a more comprehensive investigation of the effects of the individual's social support network. In the mental health literature, personal integration into a network of supportive relationships is conceived to moderate the relationship between stress and mental health.[17] Several studies have also found that the greater the number of people and types of roles in a social network, the more likely and the faster the person will seek professional help. For example, the greater tendency of females to seek help and to seek it early upon experiencing emotional problems has been linked in research to females having more friends and more readily discussing problems with them.[18] These relationships have not been investigated among Hispanic groups, although alternative resource theory suggests that their social networks, in contrast to those of whites or other minorities, should operate to keep Hispanics from using services.

Since Rogler and Hollingshead's study of schizophrenics in the slums and public housing developments of San Juan, research on Hispanic mental health has concentrated on the role of folk healers, *espiritistas* among Puerto Ricans and *curanderos* among Mexican Americans, as the main alternative to professional treatment used by Hispanics.[19] The Rogler and Hollingshead study showed that lower-class Puerto Ricans rely on spiritualists for all sorts of mental health problems, turning to professionals only if distress becomes severe. Studies which we discuss in Chapter 3 claim a similar role for spiritualism among Puerto Ricans in New York City. Research on the use of *curanderos* by Mexican Americans is more ambiguous, with some studies claiming that few use

folk healing, and others claiming that it is an important resource for Mexican Americans.

In contrast to alternative resources theory, barriers theory posits that Hispanics underutilize services because of obstacles which keep them from using services. One type of barrier may be found in subcultural values, which dispose those Hispanics who identify with them not to seek and use services. Among these are Hispanic cultural values and the process of acculturation. Edgerton and Karno[20] found that the language selected by Mexican Americans in interviews was predictive of respondents' attitudes toward conventional mental health beliefs and treatments. Those who answered in Spanish, for example, were most likely to stress prayer and other non-medical treatments for mental illness. Studies have also related Hispanic cultural values to the utilization of services. Among values mentioned are *confianza*, the value of trust; *personalismo,* trust in the immediate person, not in the organization; *respeto,* the value of respect intrinsically owed to another person; *vergüenza* and *orgullo,* the sense of shame and the value of pride; and *machismo,* the pride in manliness. Hispanics who identify with these values are predicted to shun contacts with Anglo institutions, hence leading to underutilization of services.[21] The literature has also identified specific cultural beliefs with respect to mental health that have similar consequences, for example, the stigma attached to mental illness inherent in the word *loco,* which leads to denial and suppression of mental illness symptoms, and the ascription of physical causes, biological inheritance, or supernatural causes to mental illness, which lead to delay in seeking professional treatment.[22]

Several utilization studies take the approach of subsuming the subcultural factors cited above into the notion of acculturation — the process whereby the behaviors and attitudes of a migrant group change toward the dominant group as a result of exposure to a different cultural system. Several studies have found that placement in the dominant culture side of the acculturation continuum is predictive of service utilization.[23]

The subcultural barriers explanation places the onus on the individual's identification with values which disposes him or her not to use a service. In contrast, institutional barriers explanations look for characteristics of the service agencies which keep individuals away from them. Among institutional barriers identified in the literature are geographic isolation of facilities, which may discourage Hispanics from traveling far from their neighborhoods; the lack of Spanish-speaking personnel among agency staff; and the lack of rapport between middle-class Anglo service providers and lower class Hispanics.[24] Some observers see these cultural tensions between service provider and client as pervasive, applicable not only to the service provider's notion of what is an appropriate service (for example, the notion that the client should conform to appropriate norms of self-expression and proper

behavior), but also to bureaucratic notions of the ideal petitioner (well-documented, prompt, articulate, rule-oriented). Other studies have also pointed out that restrictive funding mechanisms, inflexible patterns of service, and lack of community representation in agency planning act as barriers to utilization. Evaluations of alternative mental health programs that have attempted to redress shortcomings have reached the conclusion that elimination or reduction of these barriers results in increased utilization of services by Hispanics.

It is important to note at this point that our study does not address the applicability of barrier theory insofar as the latter touches upon institutional barriers. Because our data are individually based, a study of people's behavior and attitudes, we cannot address the question of how institutional characteristics of service agencies pose obstacles to the use of services by Hispanics. We point out in the following chapters that to examine the influences of institutional barriers, it is necessary to gather data on organizational variables such as the background characteristics and attitudes of professional personnel in service agencies. Our study inquired into and we report on how those interviewed perceive problems that they have with the agencies they have come into contact with, and our analysis addresses whether these perceptions influence people's dispositions to use services. It should be clear, however, that perceptions of problems with agencies, while illuminating the notion of institutional barriers, is not a proxy for measures of organizational characteristics. Thus, our study addresses the applicability of two explanations of underutilization grounded on observations of clients' behavior rather than organizational behavior: alternative resources and that aspect of barrier theory relevant to cultural values' influences on utilization.

To summarize the conceptual framework which guides our study: we have discussed two competing explanations of utilization — alternative resource and barrier theories. We have delineated within these two theories three factors related to the underutilization of services by Hispanics: elements of the social organization of Hispanics — the family, friends and neighbors, the folk healing institution — which function as alternatives to institutional services, and the subcultural factors and institutional characteristics of service-providing agencies, both of which are hypothesized to act as barriers to seeking and using services. As noted above, the present study focuses on only two of these factors: the social organization of Hispanics and the subcultural component of barrier theory. Our objective will be to discover the relative contributions of these two factors to the service utilization patterns of Hispanics in the study area.

This chapter has outlined the policy and theoretical issues underlying the problem of Hispanic utilization of services. In Chapter 2 we discuss the study's design and implementation, and the measures of need, use of services and variables in our model. Chapter 3 examines factors associated with the use of mental health services. Chapter 4

examines the use of services by female heads of family and Chapter 5 examines the use of services for the disabled and for the elderly. Chapter 6 summarizes the findings, comparing the use of different types of services among all groups examined. The last chapter provides conclusions and recommendations for future interventions to increase the utilization of services by Hispanics.

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2

RESEARCH DESIGN AND ORGANIZATION OF THE DATA

The primary objective of the study was to gather information about the ways in which Hispanic and other ethnic groups in an area of the South Bronx utilized social and mental health services. The research approach called for a survey of a representative sample of Hispanic, black, and white residents of the area. We designed a structured interview schedule focusing upon perceived need for and use of services. Detailed questions about such perceptions and use were asked of respondents fitting nine categories of service users: the physically or mentally disabled, the elderly, female heads of family, people with drug problems, people with alcohol problems, the jobless, crime victims, people with housing problems, and people with emotional problems. For reasons detailed in our discussion below of measures used in the analysis, we focused upon services for female heads of family, for the disabled, for the elderly and for people with emotional problems. The survey also included questions about other aspects of utilization such as knowledge of agencies providing services, sources of information about services, opinions about usefulness of services, and personal readiness to use services. This chapter's section on measures discusses in greater detail the questions used to determine need for and use of specific services, and the measures for the variables indicative of the alternative resource theory and the subcultural aspect of the barrier theory of utilization discussed in Chapter 1.

Sampling and Field Work

Our first task was to obtain a representative sample of Hispanic, black, and white residents of the Fordham-Tremont Community Mental Health Center's (CMHC) catchment area which is located in the northern sector of the South Bronx (see Figure 2.1). The area is typical of many South Bronx neighborhoods. It is residential in character, with some light industry in certain areas. Residents have access to three major commercial centers and smaller shopping strips. With one exception, specialty shops in commercial centers have been replaced by bargain and discount stores. Entire blocks of boarded-up buildings and fire-gutted storefronts are a common sight in most neighborhoods.

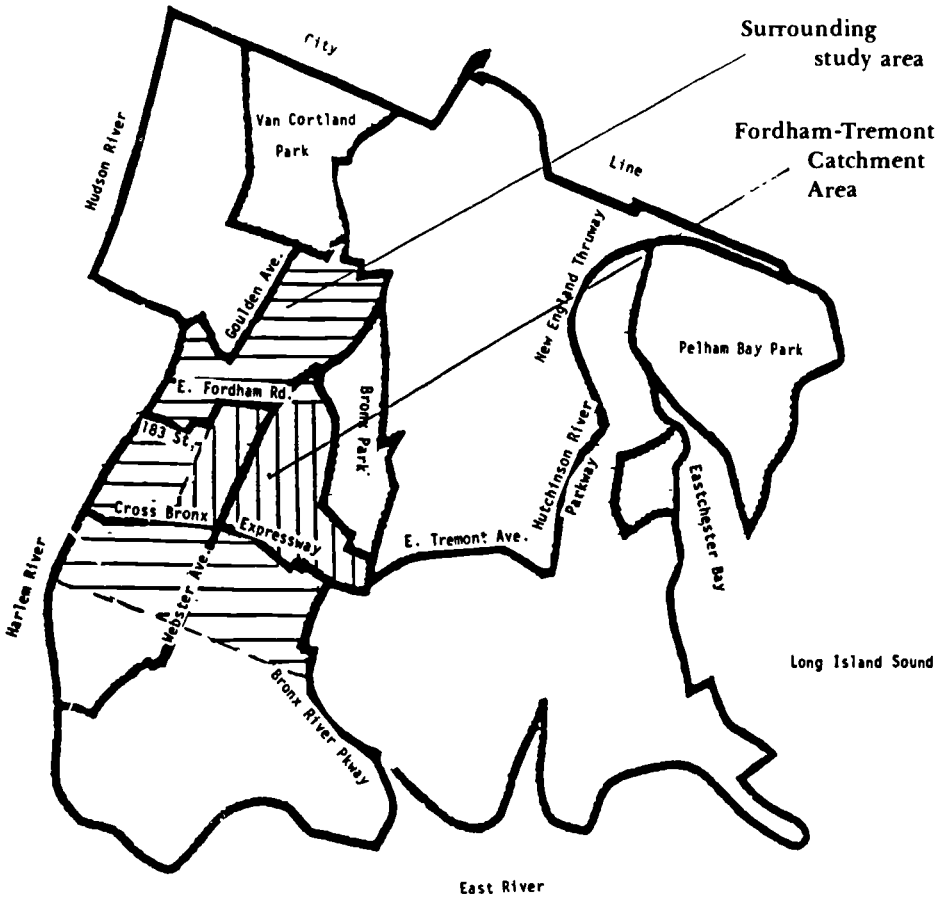

Fig. 2.1 Map of the Bronx and study area.

A review of statistics conducted by the Hispanic Research Center for the Hispanic Access proposal showed that the area had experienced major losses: from the 1960's to the 1970's there was a 40 percent loss of manufacturing jobs; 300 firms had left the area, resulting in 10,000 job losses. The area has an unemployment rate exceeding 20 percent in some communities and 25-30 percent in others. One out of every three

residents is on public assistance and three out of four students entering high school do not graduate. Per capita income in the area is 40 percent of the national average. The 1970 Census indicated that the total number of persons living in the Fordham-Tremont catchment area was 159,102. Census estimates[1] of 1980 indicate the current population to be 103,677, representing a 35 percent loss in population over a decade. In 1970 and 1980, the area's Hispanic population, which is primarily Puerto Rican, comprised approximately 50 percent of the total population.

A common problem in sampling catchment-area populations is the fact that some residents from outside the catchment area often use catchment-area facilities while some residents of the catchment area use outside-area facilities. The sampling frame was modified to reflect this. Information given to us by Fordham-Tremont CMHC indicated that only 60 percent of clients admitted between July 1980 and February 1981 lived in the catchment area. Of the remainder, 20 percent resided in neighborhoods surrounding the catchment area, and the remaining 20 percent were scattered throughout the Bronx and other boroughs in no discernible residential pattern. We therefore increased the sampling frame to include an additional 228,373 residents of neighborhoods surrounding the Fordham-Tremont area.

Table 2.1 shows the ethnic distribution of Fordham-Tremont Center clients and total 1980 census population estimates, according to residence in the catchment area, in the surrounding zone outside the catchment area, and in the rest of the Bronx. Our objective was to sample 400 Hispanic residents, 100 black residents, and 100 white residents. Within this overall figure, 60 percent of the sample would be catchment-area residents. Table 2.1 indicates that these sample proportions overrepresent whites among clients of the Fordham-Tremont center, underrepresent blacks among area residents, and underrepresent residents of the surrounding area. Our primary concern, however, was to have adequate numbers of Hispanics for in-depth analysis and adequate numbers of whites and blacks for comparative purposes.

We used a multiple-stage sampling design. In the first stage, we randomly selected 25 census tracts, 15 inside and 10 outside the catchment area. The tracts were selected with probability proportionate to size of the Hispanic population in the tract, which gave higher probability of selection to those areas with a high density of Hispanic population. This technique is helpful in reducing the number of geographical areas in which to conduct field work without losing sample representativeness.[2] One block was randomly selected from each of the 25 census tracts. In the second stage, we mapped each block and attempted to screen every third household in the block. A team of six interviewers (five bilingual) were trained to contact households according to a predetermined random pattern. Interviewers started at a predetermined building in each block and contacted one out of three

Table 2.1

Ethnic Distribution of Fordham-Tremont CMHC Client Population (July 1980 to February 1981) and 1980 Census Area Population, by Catchment and Non-Catchment Area. In Percentages.

Ethnicity	Catchment Area	Concentric Zone	Fringe Areas	Total
		CMHC Client Population		
White	9.2	10.2	14.9	10.7
Black	26.7	30.2	38.3	30 0
Hispanic	64.0	59.5	46 7	59 4
Total Number (=100%)	(543)	(225)	(201)	(969)
		1980 Census Area Population*		
White	13 0	30 7	21.9	35.0
Black	35.0	29.1	32 1	31 0
Hispanic	52 0	40 0	45 5	34.0
Total Number (=100%)	(103,677)	(228,373)	(332,050)	(1,169,115)

*Asians and Native Americans were excluded from census data computations.

contiguous households. If nobody was home, the interviewer contacted the other two households. Then the interviewer proceeded to contact the next predetermined household in the sequence. When a resident was contacted, the interviewer gave a brief description of the study and its objectives, asking the respondent for permission to interview him or her at a later time. If the respondent consented, the interviewer asked the respondent for basic information about the household — number of people, their ages, and relation to the resident contacted.

Through screening, we were able to gather basic information about 673 households of the area willing to participate in the study. This number represents 76 percent of all households contacted and 58 percent of all households selected for contact. There was substantial variation by block in the number of households we were able to contact

and the number of residents willing to cooperate with the study. Residents in predominantly white blocks — the most affluent among sampled blocks — were the hardest to reach and the most reluctant to cooperate with the study. In nine blocks where whites were at least 50 percent of the population, 69 percent of selected households were contacted, and 45 percent agreed to participate in the study. In 16 blocks where whites were less than 20 percent of the population, we were able to contact 84 percent of selected households, and 73 percent agreed to participate.

In the final sampling stage, we randomly selected approximately two out of three Hispanic residents and one out of every two black residents. Because of the small numbers, all white residents were included in the sample. Because of our interest in services for the elderly, we included in the sample all elderly residents reached through screening.

Interviewers were trained for one week before beginning field work. Training sessions included the study of written materials about the duties of interviewers (following instructions and maintaining confidentiality), how to establish a good relation with respondents and secure their cooperation, how to describe the purposes of the study, and how to answer respondents' questions about the study and the interview. Special emphasis was given to maintaining neutrality in the wording of questions, asking questions as worded, and probing when incomplete information was given. Written materials were supplemented with group sessions where the questionnaire was explained item by item and questions were rehearsed. In addition, interviewers conducted mock interviews with the project director and the field supervisor.

Field work was conducted during the last six months of 1981. The research team encountered considerable difficulties during field work. Chief among these were the inability to secure interviews because of missed appointments and respondents' absences from the households. Because of this, field work yielded insufficient numbers of black and white respondents by the projected completion date. We therefore decided to continue field work beyond the summer and into the fall of 1981 to obtain adequate numbers of black and white respondents. When field work was completed, we had interviewed a total of 381 respondents — 217 Hispanics, 87 blacks, and 77 whites. Included in these totals were 28 respondents interviewed outside the sample who were clients of a senior citizen center, and white residents living near one sampled block. These were included because of the difficulties we had in interviewing sufficient numbers of whites and of elderly residents of all ethnic groups.

Overall, the sample's ethnic distribution underrepresents blacks, overrepresents Hispanics, and represents whites in proportion to their numbers in the area's population. In our sample, 57 percent of

respondents are Hispanic, 20 percent are black and 23 percent are white. Combining the Fordham-Tremont CMHC's catchment area and the concentric area selected for sampling, 46 percent of the 1980 census population are Hispanic, 32 percent are black, and 22 percent are white. Blacks are underrepresented and Hispanics overrepresented in similar ratios inside and outside the Fordham-Tremont catchment area.

Sociodemographic Characteristics of the Sample

In this section we present an overview of the sample's demographic and socioeconomic characteristics. The data presented in Table 2.2 are based on two different units of observation: the respondent and the household. For example, age and sex data refer to the respondent, while family structure and income data refer to the household. This information is labeled accordingly.

The vast majority of respondents are women. Males are underrepresented because they were harder to reach during daylight hours, were not part of many households, and were less willing to participate in the survey than women. However, if an adult male lived in the household, we systematically collected information about him through questions about the characteristics and service needs of all household members.

Table 2.2 shows that one-fifth of Hispanics and four-fifths of blacks and whites are over the age of 60. Because we included in the sample all elderly residents reached through screening, the age distributions of the ethnic groups do not reflect census estimates. According to the 1980 census,[5] approximately 10 percent of Hispanics and blacks, and one-third of whites in the Fordham-Tremont area are over the age of 60. The proportions of Hispanic and black elderly are the same as estimated for the Bronx as a whole, but the proportion of white elderly is higher than that estimated for the Bronx as a whole. In Chapter 5, we examine the implications of the high proportion of elderly whites for services in a predominantly minority area. In spite of their equal proportions of people over 60, blacks in the sample are on an average younger than whites: 24 percent of blacks are under 30 years of age, as compared to 12 percent of whites and 20 percent of Hispanics.

We compared the three ethnic groups on their family structure. Table 2.2 shows that 39 percent of Hispanic households are headed by a single female with children under 18, in contrast to 25 percent of black households. Only 29 percent of Hispanic households and 24 percent of black households are headed by two partners, in contrast to 48 percent of white households. Length of residence in an area is an indication of the individual's stability in the community. Table 2.2 shows that over half of Hispanic residents have lived at their present address for less than three years. Blacks and whites have lived longer in their respective areas: 29 percent of blacks and 61 percent of whites have

lived at their present residence for over 10 years, as compared to only 13 percent of Hispanics.

The area's three ethnic groups were compared on income level, sources of income, and education. We computed total family income by adding the incomes of all members of the household. Income refers to salaries, public assistance, benefits such as social security, and financial assistance from relatives not living in the household.

The general poverty in the area is highlighted by the fact that two-fifths of households receive less than $5000 a year. However, there are substantial income differences between white and minority households. Half of black and Hispanic households receive less than $5000 yearly, while only 15 percent of white households do so. At the other extreme, three-fifths of white households receive more than $10,000 a year, compared to one-fourth of black and Hispanic households.

While the income distribution of Hispanic and black households is similar, Hispanics on an average have larger families and, therefore, smaller per capita income in the household. The mean per capita income of Hispanic households is $2891, while that of black and white households is $4623 and $8526, respectively.

Table 2.2 shows the sources of household income. The category "benefits" refers to sources other than public assistance, such as veterans' benefits and social security. One-fifth of black and Hispanic households derive their main source of income from work, as compared to 36 percent of white households. Since Hispanics have the highest proportion of female-headed families, they also have the highest proportion of households subsisting on public assistance. Black and white households, with higher proportions of elderly persons, have higher proportions of individuals relying on benefits other than public assistance such as social security and Supplementary Security Income.

Table 2.2 also shows each ethnic group's level of education. Hispanics have the lowest educational level of all groups. The overall mean for the sample is nine and a half years of education, but the overall mean for Hispanics is more than one year below that figure. Fifty percent of all Hispanic respondents have less than 9 years of education, as compared to 22 percent of blacks and 6 percent of whites. At the other extreme, high school diplomas were held by one-fifth of all Hispanics, one-third of all blacks, and one-half of all whites.

Taking into account income levels, income sources, and education, Hispanics are the most socioeconomically deprived group in the area and whites are the most affluent. However, regardless of ethnicity, few residents in the area may be considered to be even moderately affluent, indicating that this is an area in great need of human services.

Table 2.2 shows some aspects of the Hispanics' immigration experience. More than four-fifths of Hispanics in the area were born outside the United States. Nine out of ten Hispanic immigrants were born in Puerto Rico. Over two-thirds of the Hispanic immigrants came

Table 2.2

Selected Demographic and Socioeconomic Characteristics of Fordham-Tremont Area Households and Residents, According to Ethnicity. In Percentages.

Characteristics*	Hispanic	Black	White	All Groups
Sample Size				
Number	57 (212)	23 (87)	20 (77)	100 (381)
Sex				
Male	16	15	24	17
Female	84	85	76	83
Age Groups				
20 years or less	3	4	7	3
21-29	17	20	5	15
30-39	26	17	20	23
40-49	19	9	14	16
50-59	14	9	16	13
60 or more	21	41	38	30
Mean Age	(44)	(49)	(56)	(48)
Years Living at Current Address				
1 or less	17	13	9	15
2-3	35	27	7	27
4-10	35	31	23	32
11 or more	13	29	61	26
Mean Years	(7.7)	(11.9)	(16.1)	(10.4)
Family Structure				
Female-headed with children under 18	39	25	6	29
Two-parent or partner households	29	24	48	32
Single females	12	30	22	18
Single males	3	6	9	5
Other	17	15	15	16

Characteristics*	Hispanic	Black	White	All Groups
Family Income				
Less than $5000	46	49	15	41
$5000-$10,000	31	26	24	28
Over $10,000	23	25	61	31
Mean Income	($6080)	($5392)	($12,731)	($7256)
Family Income Sources				
Salary only	18	20	36	21
Salary & benefits	0 4	2	—	0.2
Public assistance	41	29	9	32
Salary & public assistance	3	2	—	0 8
Benefits only	37	46	55	43
Educational Level				
8 years or less	50	22	6	35
9-11 years	30	41	15	31
12 years or more	20	36	79	34
Mean Years	(8 2)	(10 3)	(12.1)	(9.5)
Age when Came to U.S. to Settle				
18 or less	36			
19-35	50			
36 or more	14			
Mean Age	(23)			
Number of Years in U.S.				
10 or less	14			
11-20	27			
21-30	31			
31 or more	28			
Mean Years	(24)			

*Missing data have been deleted from calculations and percentages have been rounded off.

to the United States after the age of 18, that is, after they had been fully socialized to Hispanic culture. On the other hand, Hispanics in the area are not recent immigrants: only 14 percent have been in the United States for less than 10 years.

To summarize the sociodemographic characteristics of area residents: Each ethnic group in the area has a distinctive socioeconomic and demographic profile. Hispanics are younger, less educated, more likely to live in female-headed families, less residentially stable, poorer and more likely to depend on public assistance for income, and mostly born outside the United States. Blacks are also poor but less dependent on public assistance and, on the average, older than Hispanics. Whites are, on the average, the oldest group in the area and the most educated and affluent, though not affluent by national standards.

Measures of Utilization and of Explanatory Variables

Our survey inquired into the use of a broad range of social and mental health services: services for the disabled, for the elderly, for female heads of family, for the unemployed, alcoholism and addiction services, services for crime victims, housing, and mental health services. However, the analysis presented here focuses upon the use of services for four groups: the disabled, the elderly, female heads of family, and people with emotional problems. We did not get usable responses to our questions about alcoholism and addiction, victim services, unemployment and housing. Few respondents reported needs among household members for alcoholism and addiction services. We believe this was partly due to reticence on the part of some respondents. With respect to services for crime victims, 5 percent of respondents reported being victimized within the past year, which did not yield a sufficient number of cases for analysis. With respect to unemployment, the majority of household members without jobs were housewives or students, who by strict economic definitions are out of the labor force. Most respondents indicated needs for housing services, but the services asked about dealt with landlord/tenant relations and public housing, not fitting our analysis which focused on interpersonal services.

For each type of service, we inquired about the need for and the use of a set of specific services. For example, with respect to the disabled we asked about the use of employment counseling, transportation, and other services specifically available for disabled people. It should be noted that for each of these groups, we could have asked about many other services. For example, one study of needs assessment for the elderly lists over 20 services that they could receive.[4] Thus, we had to make choices about the services to inquire into. The services we examined were selected after conversations with service providers in the area who mentioned the types of services they believed were most needed by the different populations.

Agencies apply complex bureaucratic and professional criteria to a person's case to determine eligibility for services. In a field survey, assigning a respondent to a given service-eligible group can only approximate the more complex bureaucratic process used to determine eligibility. Thus, it should be noted that household members defined as service-eligible share attributes associated — but not necessarily equated—with need for a given type of service. This will become evident when we discuss the criteria for service eligibility used in the study.

Respondents were asked about household members' and their own needs for services only when at least one household member fulfilled the criteria for that service population. We illustrate with the example of the disabled and then list the criteria for the other three service populations examined in this study. With respect to the *disabled,* all respondents were asked the following question: "Is there anyone who lived in your household in the past year who has a special problem that prevents him or her from carrying out things like work, housework, or schooling, for example, loss of hearing, loss of sight, loss of speech, or others?" Only if the respondent answered "yes," was he or she asked questions about the need for and the use of specific services for the disabled. Interviewers were instructed to emphasize the inability to carry out normal activities when asking the above question.

The selection criteria for the other service populations were as follows:

The elderly. Any person over the age of 59 who had lived in the household at any time within the 12 months prior to the interview.

Female heads of family. Any female household member who was no longer living with the father of her children. Included were some women with children living with men who did not regularly contribute income to the household.

People with emotional problems. Members of households in which the respondent answered "yes" to the question, "At one time or another, almost everybody has an emotional problem, for example, feeling angry all the time, or feeling low often, or fighting with friends and relatives over little things, or feeling worried all the time. In the past 12 months, did you or anyone in your household have any emotional problems?" As an additional measure of need for mental health services, respondents were administered the short version of the Demoralization Scale, developed by Bruce Dohrenwend and associates[5] out of the Psychiatric Epidemiology Research Interview. This scale is described in detail in Chapter 3.

Table 2.3 shows the percentage of Hispanic, black, and white households in the sample who were classified into each of the four service categories. In the Fordham-Tremont area, minorities are found in greater percentages than whites among all service-eligible populations except the elderly. Among minorities, more Hispanics than

blacks live in female-headed households, but equal proportions of these households have disabled members. Hispanics are also more likely than blacks or whites to report having people with emotional problems in the household.

Table 2.4 shows how households of the three ethnic groups overlap on the services for which they are potentially eligible. The table shows the percentage of a given service-eligible group found among other service-eligible groups. For example, the uppermost cell on the left shows that 31 percent of Hispanic households with a disabled person also have an elderly person. It is important to note that the overlap in service-eligible persons may refer to the same individual or to another member of the household. The table may be seen as a probability matrix, i.e., if we know that someone in the household is eligible for a given type of service, the table gives the probability of that person or any other household member being eligible for other types of services.

Some of the high probabilities found on the table show the dramatic service needs of families in the area. Of particular note is the high association between disabilities and emotional problems. Among Hispanics, for example, half of the households with disabled people also have a person with emotional problems. This may indicate that the disabled person has emotional problems or that the disability contributes to emotional problems among other household members.

Table 2.4 also shows that black and white households with disabled people are very likely to have an elderly person. Hispanic households with disabled people have fewer elderly members, but are more likely than the others to be female-headed. The converse is also true; among

Table 2.3

Types of Service-Eligible Households, According to Ethnicity

Service-Eligible Type	Hispanic		Black		White		All Groups	
	%	N	%	N	%	N	%	N
Disabled person in household	25	(54)	26	(23)	18	(14)	24	(91)
Elderly person in household	25	(54)	39	(34)	51	(39)	33	(127)
Female head of family	43	(94)	29	(25)	5	(4)	32	(123)
Person with emotional problem in household	24	(52)	16	(14)	17	(13)	21	(79)

minority households with elderly members, disabilities are common. In all ethnic groups, households with elderly members are less likely than others to have people with emotional problems. Although the greatest overlaps are between disabilities, elderly status, and emotional problems, female-headed households also show substantial overlap with disabilities, having an elderly household member, or having a household member with emotional problems.

The proportions of households in Table 2.4 overlapping in eligibility for services illustrate the existence in inner-city neighborhoods of multiple-problem families. To explore this, we examined the extent to which households were eligible for more than one type of service. We classified households according to the number of service combinations for which they were potentially eligible. Overall, 90 percent of households were eligible for one type of service, that is, for the disabled, for the elderly, for female heads of family, or for people with emotional problems. Approximately half of the households fell into a single service category, one-fourth fell into two service categories, and 10 percent were potentially eligible for three or more types of services. Hispanics and blacks were more likely than whites to have households eligible for two or more types of services. An examination of the households falling into two or more service-eligible groupings shows no preponderance of any ethnic group in a particular combination of service populations.

Now that we have discussed the measures of utilization, we describe the measures used as indicators of the explanatory factors. The survey includes measures indicative of the two theories of underutilization — alternative resources and the subcultural aspect of barrier theory. To recall our discussion of the two theories in Chapter 1, alternative resources theory hypothesizes that Hispanics underutilize services because they rely for help on culturally proximate and familiar institutions: the family and the *compadrazgo* system, folk healers, and friendship networks. Barrier theory hypothesizes two kinds of barriers which prevent Hispanics from using the services they need: institutional barriers imbedded in the characteristics of the agencies providing services — which are not examined in this study, and cultural barriers, the norms and values which proscribe the use of bureaucratically organized services.

With respect to reliance on alternative resources, our measures reflect characteristics of the respondents' social networks. We asked respondents whether they had needs such as help with housework, companionship, and advice with personal problems, and on whom they relied for such help. Their responses were classified according to the number of areas for which they reported receiving help, and the types of persons mentioned — household members, relatives, neighbors, friends, or associates. The last category includes persons such as building superintendents, grocers, landlords, and work supervisors, and thus refers to members of the social network placed in formal social

Table 2.4

Overlap in Service-Eligibility Among Households, According to Ethnicity. In Percentages.

Ethnicity and Service-Eligible Group	Disabled	Elderly	Female Head of Family	Emotional Problem	N
Hispanics					
Disabled	—	31	35	46	(54)
Elderly	31	—	13	18	(54)
Female head of family	20	7	—	28	(94)
Emotional problems	48	19	50	—	(52)
All Hispanics	25	25	43	24	—
Blacks					
Disabled	—	50	27	27	(28)
Elderly	32	—	3	9	(34)
Female head of family	24	4	—	20	(25)
Emotional problems	43	21	35	—	(14)
All Blacks	26	39	29	16	—
Whites					
Disabled	—	50	14	50	(14)
Elderly	18	—	3	15	(39)
Female head of family	*	*	—	*	(4)
Emotional problems	54	46	23	—	(13)
All Whites	18	51	5	17	—

*Numbers in base too small for computations.

roles. Responses were also classified according to the total number of people mentioned, the total number of help instances by each type of helper, how frequently each person was seen, whether the person lived in the neighborhood or further away, and other background characteristics of these people. We found no significant differences among the ethnic groups in these social network characteristics, with the exception that a greater proportion of Hispanics report members of their social networks as seeing each other on a daily basis. Our analysis chapters explore the relevance of this to utilization of services among Hispanics.

With respect to cultural barriers, the survey includes information related to the person's migration background: the number of years in the U.S. (for those born in Puerto Rico) and the age at which the person entered the U.S. to settle permanently. Respondents were also administered Cuellar et al.'s acculturation scale,[6] which taps four dimensions of adherence to Hispanic culture: Spanish-language use and preference, preference for the Hispanic cultural heritage (food, music, Spanish-language media), cultural identification, and the ethnic groups the person associates with. Mean scale scores range from 1 for completely unacculturated (responses indicating "only Spanish" or "mostly Spanish") to 5 for completely acculturated responses indicating "only English" or "mostly English." The mean score for respondents was 1.9, indicating that the majority of Hispanics in the area are oriented to Hispanic culture.

Students of the migration process distinguish between acculturation, the psychological process of internalizing the norms and values of the host culture,[7] and structural integration, insertion into social roles typical of people born in the host society.[8] A migrant may be strongly integrated into the host society and yet be oriented to her/his native culture. From the viewpoint of structural integration, factors such as English-speaking ability or the ethnic groups the migrant associates with are more important than language or food preferences. This is because attributes such as knowledge of English are assumed to be more important than attitudes in influencing access to economic opportunities. Our analysis of responses to the scale does not support this assumption. We divided the acculturation scale into two subscales: a cultural orientation scale consisting of items denoting cultural preferences such as the types of food preferred and the degree of identification with Hispanics; and a social integration scale tapping behavioral items such as the language most used and the ethnic groups associated with. Scores in the two subscales are highly correlated and either subscale has the same degree of association with other variables in the data. Thus, in our analysis, we used the acculturation scale consisting of both behavioral and attitudinal items.

The survey also included questions about Hispanics' cultural values of mental illness. Using the methodology developed by Star,[9] respondents were read 11 short descriptions of persons with psychological

disturbances typically coming to the attention of clinicians. A sample vignette will indicate the intent of the questions:

> Now here's a man — let's call him Victor, who is very suspicious; he doesn't trust anybody and he's sure everybody is against him. Sometimes he thinks that people in the street are talking about him or following him around. A couple of times now he has beaten up men who didn't even know him. The other night he began to curse his wife terribly, then he hit her and threatened to kill her because, he said, she was working against him too, just like everyone else.

The vignettes described the following behaviors: paranoid delusions, alcoholism, hysterical attack, hallucinations, menopausal disturbance, anxiety, juvenile delinquency, fear of being bewitched, compulsive behavior, "workaholic" behavior, and religious visions. For each vignette, the respondent was asked if the person had a problem and, if so, how serious; to indicate what the problem should be labelled (mental illness, nervous problem, madness); and if the person described should see somebody about the problem. Responses to the kind of problem the behavior described were not useful to our analysis because there was little variability in responses. However, respondents differed on how serious they thought the behavior to be and whether someone should be seen about it. The majority of the three ethnic groups agreed on the seriousness of the behaviors and on the opinion that the persons should see someone about them, but smaller proportions of blacks and Hispanics considered these cases as serious as whites did. Hispanics' ratings of the vignettes on menopause, compulsion, and religious visions were significantly lower in seriousness than the other groups', and blacks' ratings of the anxiety and workaholic cases were significantly lower than the other groups'. Taking the ratings of the 11 vignettes as a seriousness index and as an index of need for help, Hispanics' ratings were significantly lower than the other groups'. In line with the cultural barriers explanation of utilization, this suggested that perceptions of the seriousness of mental illnesses might influence minority groups not to seek mental health services. We investigate this hypothesis in Chapter 3.

Barrier theory also posits that organizational characteristics of service agencies such as the lack of Spanish-speaking personnel and the class orientation of service providers may pose obstacles to the use of services by Hispanics. To determine how organizational characteristics may act as barriers, it is necessary to directly measure those characteristics among an adequate sample of mental health agencies. Since our survey focused on the behavior and opinions of residents, our approach precluded direct measures of the characteristics of mental health organizations in the area. However, we asked respondents about the frequency with which they experienced 18 common problems in

seeking and receiving services from local agencies, for example, lack of attention by agency personnel, inability of personnel to speak Spanish, and having to make many appointments before being served. We divided these problems into three types: the kind of personal treatment given by agency staff, the language barrier, and difficulties in seeking or receiving services. In the next three chapters we examine how respondents' perceptions of problems with agencies influence their use of mental health and social services.

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3

MENTAL HEALTH SERVICES

In the Fordham-Tremont area, people experiencing psychological distress have several recourses. Residents may use psychiatric services available at the Fordham-Tremont Community Mental Health Center (CMHC) and at the outpatient psychiatric clinics in hospitals in nearby areas. Residents with more severe psychological disturbances may use the short-term psychiatric ward of the Fordham-Tremont catchment area's general hospital, other hospitals' psychiatric wards, or the state psychiatric hospital servicing the Bronx. This complex of facilities constitutes the treatment system designated by New York City's and New York State's mental health system. Area residents with psychological problems also make use of other help-givers: physicians (many of whom provide services in "Medicaid mill" operations) and spiritualists who provide services out of their homes or out of store fronts. This chapter examines how Hispanic and other residents of the area with psychological problems make use of official and unofficial help-givers.

Because previous literature which we discuss below argues that Hispanics and other minority group members underutilize mental health facilities, this chapter examines barriers to the utilization of mental health services by Hispanic, black, and white residents of the Fordham-Tremont area. As discussed in Chapters 1 and 2, our analysis tests the applicability of two theories of Hispanic underutilization: alternative resources theory and the subcultural aspect of barrier theory. Alternative resources theory posits that Hispanics underutilize services because they rely on relatives and friends in their informal networks who provide an alternative to the help provided by the official agency system. The subcultural aspect of barrier theory, which we examine here, posits that Hispanics underutilize services because of cultural values they hold which make unattractive the kind of help provided in bureaucratically managed service agencies.

Literature on Utilization of Mental Health Services

Admission rates, taken as evidence of utilization of mental health facilities, are based upon the proportion of users of mental health facilities who are members of a racial/ethnic group in relation to that

group's proportionate size in the population of the area being served by the mental health facility. When the first proportion is smaller than the second proportion, the group is said to underutilize; when the first proportion is larger than the second, it is said to overutilize. Admission rates have also been used to make interethnic or interracial comparisons in determining over- or underutilization.

Research findings based upon the procedure described above generally point to Hispanic underutilization of mental health facilities. Bachrach's study[1] of Hispanic utilization of mental health services concluded that Hispanics were underrepresented in their admissions to inpatient psychiatric units of state and county hospitals throughout the United States. Since that time, several national surveys have been administered by the National Institute of Mental Health with the results generally agreeing with those of Bachrach. Hispanics have been found to underutilize outpatient psychiatric services, private psychiatric hospitals, and the psychiatric services of non-public, non-federal, general hospitals[2]. At the same time, Hispanics were found to overutilize the inpatient psychiatric services of public non-federal general hospitals.

Studies examining utilization of mental health services among Mexican Americans have generally indicated underutilization. Karno and Edgerton[3] found that in 1966 Mexican Americans comprised only 3.3 percent of the resident population of California's state hospitals for the mentally ill, at a time when Mexican Americans comprised 9 to 10 percent of California's population. Sue's examination[4] of mental health service utilization rates among different ethnic groups in Seattle also found that Mexican Americans underutilize mental health services.

Studies of admissions to mental health facilities in New York State have generally shown less underutilization among Puerto Ricans. Several studies of local New York City catchment areas conducted during the 1970's indicated that Puerto Ricans had higher admission rates than other ethnic groups. In a study of service delivery to mentally ill residents of the Metropolitan Community Mental Health Center catchment area from 1970 to 1973,[5] the admission rates for non-Hispanic whites were considerably lower than those for blacks and Puerto Ricans. Similarly, for inpatients, Puerto Rican admission rates were twice those for whites. Another study conducted at the same time in the Bellevue catchment area of New York City[6] found that admission rates for Puerto Ricans and blacks were higher than those for whites. It was found that a significant portion of this discrepancy was the result of the practice of upper middle-class whites to use facilities outside of the catchment area, while the Puerto Rican population of the area was found to use the local facilities to a greater extent than did either black or white non-Hispanic residents.

Two other studies of admissions in New York City indicate higher rates for Puerto Ricans. Alers,[7] also using New York City figures for

admission to all local community mental health and retardation facilities, reported that the total admission rate for Puerto Ricans was approximately twice that for non-Hispanics. Canino et al.[8] constructed a mental health profile of Puerto Rican children, relative to other New York City children, based upon the New York State Department of Mental Hygiene's admission form (MS-5). The data showed that the rates of reported admission interviews for Puerto Rican and black children were considerably higher than those for non-Hispanic white children, with the highest rates found among Puerto Rican children.

The above-cited studies had to rely on incomplete admissions data. More recent admission rates published by New York State and based on more comprehensive data collection clearly indicate that Puerto Ricans and other Hispanic groups in New York City underutilize mental health services. The one-week survey of patient characteristics conducted by New York State's Office of Mental Health[9] estimated that in 1981, 10,150 New York City residents were treated in inpatient and 33,270 in outpatient facilities. Among all adult outpatients, 17 percent were Hispanic, 26 percent were black, 56 percent were white, and 1 percent were Native Americans or Asian Americans. Expressed as rates, 861 out of every 100,000 Hispanics were admitted to outpatient mental health facilities, while the admission rates for blacks, whites, and Native Americans and Asian Americans were 1104, 1046, and 303, respectively. Admission rates for inpatient facilities showed even greater ethnic differentials, with 170 admissions for every 100,000 Hispanics, and 324, 231, and 70 admissions for every 100,000 blacks, whites, and Asian and Native Americans, respectively. In the Bronx, Hispanics and blacks had similar outpatient admission rates, but Hispanics had lower inpatient admission rates than blacks or whites. The New York State data thus provide evidence that, with the exception of Native Americans and Asian Americans, Puerto Ricans and other Hispanics have the lowest utilization rates among New York City's ethnic groups.

As indicators of utilization, admission rates are limited because they are computed on the basis of the total population, rather than that segment of the population that is mentally ill. To obtain more accurate utilization data, studies must take into account epidemiological estimates of the number of people in the population with varying degrees of clinical pathology. Hispanics have been studied in a relatively small number of epidemiological studies. With respect to Mexican Americans, Roberts[10] found only three ethnically comparative studies,[11] all of which indicate that Mexican Americans' prevalence rates were lower than whites' but higher than blacks. Roberts' own study found Mexican American and black rates to be higher than whites'. Depending on the measures Roberts used, Mexican Americans' rates were higher or lower than blacks'. In comparison, studies of Puerto Ricans in New York City

indicate that Puerto Ricans have rates of distress higher than blacks' or whites'. Srole's Midtown study[12] found that the small number of Puerto Ricans in his sample had the highest rates of psychological distress of all groups. Dohrenwend et al.,[13] in their studies of residents of the Washington Heights area of New York City, used the same psychological distress scale as used in the Midtown study (Langner's 22-item scale).[14] They also found that Puerto Ricans had higher distress rates than any of the other ethnic groups. Since Antunes' study of Mexican Americans also used the Langner scale, we are able to compare Mexican Americans and Puerto Ricans. Using the commonly employed cutting point of four or more symptoms as evidence of psychological impairment, we find that 30 percent of Mexican Americans and 37 percent of Puerto Ricans fell into the "impaired" category. It should also be noted that the distress score found for Puerto Ricans in New York City was lower than the score found for whites by Antunes et al.,[15] where 44 percent of whites fell into the "impaired" category.

Since most epidemiological studies of New York City show that Hispanics have mental illness rates greater than whites' and at least equal to blacks', the admissions data we reviewed indirectly suggest that Hispanics underutilize mental health services more than their admissions rates indicate. The findings from these aggregate data studies also point to the need to conduct research which measures at the individual level both the use of mental health services and the need for mental health services, as indicated by symptom scores in a mental illness scale. Thus, our analysis examines the use of mental health services by Hispanic, black, and white residents controlling for the number of psychological distress symptoms reported by respondents.

Utilization Patterns

We measured utilization of mental health services by asking about respondents' use of the following during the year preceding the interview: inpatient treatment, outpatient treatment (either in a community mental health center or a hospital clinic), private psychotherapeutic treatment, treatment by a non-psychiatric physician, and participation in a preventive mental health program. Questions about use of these services were asked of those who responded positively to a question about having emotional problems during the year preceding the interview. To check responses, all respondents were asked a second question about the use of mental health services. With few exceptions, we found responses to the two questions to be consistent.

Table 3.1 shows Hispanics', blacks', and whites' responses to the questions about use of mental health services. The table shows that there is considerable preference among all ethnic groups for physicians and outpatient services in treating emotional problems. Fewer respondents reported a preference for hospitalization or preventive programs. The rejection of inpatient treatment is understandable, given the fact

that both patient and clinician see it as a treatment of last resort. Consequently, it is also understandable that among the few who reported needing inpatient treatment, the majority received it.

Table 3.1

Use of Mental Health Services Among Those Acknowledging Emotional Problems, According to Ethnicity. In Percentages.

Type of Service	Hispanic	Black	White	All Groups
Hospitalization				
Needed	11	7	8	10
Received	9	7	8	9
Not Received	2	0	0	1
Not needed	89	93	92	90
Total Number (=100%)	(52)	(14)	(13)	(79)
Outpatient Services				
Needed	56	21	15	43
Received	43	14	15	36
Not received	7	7	0	7
Not needed	44	79	85	57
Private Therapist				
Needed	30	14	23	27
Received	25	7	8	20
Not Received	5	7	15	7
Not needed	70	86	77	73
Physician				
Needed	40	21	62	40
Received	40	21	62	40
Not received	0	0	0	0
Not needed	60	79	38	60
Preventive Program				
Needed	23	7	8	18
Received	13	0	0	9
Not Received	10	7	8	9
Not needed	77	93	92	82
All Mental Health Services (Except Physicians)				
Needed	83	36	46	68
Received fewer than needed	16	15	15	15
Received all needed	67	21	31	53
No services needed	17	64	54	32

The numbers of blacks and whites reporting emotional problems are small, but they allow us to discern some ethnic differences in preferences for and use of different types of mental health services. Hispanics are much more likely than blacks or whites to report a need for outpatient services, while whites are more likely than Hispanics or blacks to need private physicians. The majority of blacks, on the other hand, consistently report a need for all mental health services. Among the services, outpatient services, private therapy, and preventive programs are particularly underutilized. For example, one-third of those who reported needing private psychiatrists report not receiving that service. Physicians and inpatient services, on the other hand, are better utilized among those who report needing them. Hispanics who need these services are more likely to receive them than blacks or whites.

Table 3.1 summarizes the proportions among the three ethnic groups reporting a need for and use of mental health services. We see a dramatic difference between Hispanics and the other two groups in the proportions reporting a need for services. Four-fifths of Hispanics who acknowledged having emotional problems reported needing one or more services, and two-thirds received all services reported needed. Much smaller proportions of blacks and whites reported needing and using services. On the basis of reported need, lower proportions of blacks and whites than Hispanics utilize services. Excluding those reporting no need for services, four-fifths of Hispanics, three-fifths of blacks, and two-thirds of whites received all services needed.

The results described in Table 3.1 are based on those respondents who acknowledged having emotional problems. We considered the possibility that some people with emotional problems may not acknowledge them, or acknowledge them but not feel that they need professional help. To obtain an objective measure of psychological distress to compare with respondents' self-reports of emotional problems, we administered to respondents Dohrenwend et al.'s short version of the Demoralization Scale, which is based on the more extensive Psychiatric Epidemiology Research Interview (PERI).[16] A brief discussion of the Demoralization Scale will be helpful before examining the relationships between psychological distress, acknowledgment of emotional problems, and use of mental health services. A discussion of the reliability of the scale is found in the Appendix.

The Demoralization Scale measures eight clusters of symptoms related to Frank's[17] definition of demoralization: *dread,* the fear of being unable to control one's own feelings; *poor self-esteem,* feelings of low self-worth; *hopelessness-helplessness,* feelings that little in life is positive; *anxiety*, worry, restlessness, and tension; *confused thinking,* trouble in thinking or concentrating; *sadness,* feelings of depression and loneliness; *psycho-physiological symptoms,* somatic manifestations of negative emotions; and *poor physical health.* These eight clusters were chosen by Dohrenwend et

al. because they were the most highly intercorrelated among 25 symptom-clusters chosen for high reliability. Since we were interested in general indicators of need for treatment, we used a non-specific measure of psychological distress rather than clinically oriented measures of specific pathologies. An additional consideration on our part for not using a clinically oriented scale is that the latter is difficult to administer in field situations by clinically inexpert interviewers. Two additional considerations tilted us toward using the Demoralization Scale: a short version using the most predictive items (27 out of 49 items) was available, and a field-tested Spanish-language version was available.

To maximize frankness in answering the Demoralization Scale, interviewers read the symptoms, but respondents marked their answer on a separate sheet depicting the responses as boxes to be checked. The first question was a neutral item which allowed the interviewer to correct the scoring instructions if they were misunderstood. Respondents were told that their scoring sheets would not be identified with their name, and the scoring sheet was inserted into an envelope after all items were scored. Inspection of the scoring sheets showed that respondents had answered the questions conscientiously: most respondents varied their response item by item, as would be expected from a careful respondent. Respondents were asked to answer in terms of the 12 months preceding the interview.

Table 3.2 shows the mean number of symptomatic responses for each of the ethnic groups, according to the eighty symptom-clusters described above. The symptoms are ranked in a Likert-type scale where response categories are of the type "very often, often, sometimes, almost never, never," or "very much like you, much like you, somewhat like you, very little like you, not at all like you." Symptomatic responses were classified as the last two responses for items expressed positively, for example, feeling confident, and the first two responses for items expressed negatively, for example, feeling useless.

For most symptoms, one out of four respondents gave a symptomatic response. Symptomatic responses were particularly high in the anxiety, sadness, and hopelessness/helplessness clusters, and generally lower for the other clusters. The most notable feature of Table 3.2 is the comparatively greater number of symptomatic responses among the sample's Hispanics. Hispanics had a significantly higher percentage of symptomatic responses in 24 out of 27 items, and in 7 out of 8 clusters. In the poor self-esteem cluster blacks had more symptomatic responses, but the differences between Hispanics and blacks in that cluster were not statistically significant. In general, the difference in a given symptom between the Hispanic symptomatic response and the next lowest was 10 percent. Overall, Hispanics had a mean number of 5.8 symptomatic responses, almost two symptoms more than blacks or whites. The overall Hispanic responses suggest that Hispanic residents in the area manifest the pattern of higher psychological distress found

Table 3.2

Mean Number of Symptomatic Responses by Demoralization Cluster, According to Ethnicity

Demoralization Cluster	Number Of Items	Hispanic	Black	White	All Groups
Poor self-esteem	6	.72	74	.55	69*
Hopelessness/ helplessness	4	1.04	.63	.54	84
Dread	3	44	.18	.14	.32
Confused thinking	2	.42	27	26	36
Sadness	2	.69	.42	35	.52
Anxiety	6	1.79	1 00	99	1 46
Psycho-physio-logical symptoms	3	.54	.52	31	.49
Poor physical health	1	.29	.17	.11	.22
Total Scale	27	5.93	3.93	3.25	4.90

*Chi-square statistics not significant for this cluster. Interethnic differences for the other clusters and for the scale are significant at .10 or lower.

in other New York City studies.

Table 3.3. examines the use of mental health services among Hispanics, blacks, and whites according to the number of demoralization symptoms they reported. The number of symptoms were grouped approximately into terciles — one or no symptom, two to seven symptoms, and eight or more symptoms. In the analysis below of factors associated with utilization, we indicate that currently there is no information on the number of demoralization symptoms which indicate clinical pathology. Thus, the symptom groups can only be interpreted as showing increased psychological distress. We classify these groups as low symptom, medium symptom and high symptom.

As would be expected, the greater the number of reported symptoms, the more likely people are to report emotional problems. However, it is notable that among the high-symptom group, the majority of blacks and Hispanics do not report emotional problems and thus do not use mental health services. The results with respect to whites are difficult to interpret because of the few whites in the high-symptom group. Not acknowledging such problems is the main source of underutilization among Hispanics with a high number of demoralization symptoms.

Among blacks, another important source of underutilization is not perceiving a need for services even when acknowledging having emotional problems. Thus the table suggests substantial underutilization of mental health services among all ethnic groups. With respect to minorities, underutilization is mainly due to not acknowledging emotional problems. The table also suggests that acknowledgment of emotional problems constitutes a separate and independent factor in utilization. Support for this is found in the mental health pathways literature[18] which posits the recognition of having an emotional problem as a necessary step in the decision to seek psychotherapeutic help. Thus, we incorporate acknowledgment of having an emotional problem as an additional factor in our analysis.

Utilization by Hispanics

The survey included measures indicative of alternative resources and barriers theories. These measures, which we describe generally in Chapter 2, are discussed here in greater detail, along with measures used only in the analysis of mental health services. With respect to reliance on alternative resources, respondents' answers to questions about their social networks were classified according to the number of areas in which they reported receiving help, the types of persons mentioned (household members, relatives, neighbors, friends, or associates), and according to characteristics of the members of the social network. We used responses to these questions to construct three indices of social network integration: size, the total number of people mentioned; a composite index of the total number of help instances by members of the social network; and an index of the frequency of contacts with members of the social network other than household members. We also asked respondents about the use of spiritualists for help with emotional problems. We found that less than 5 percent of respondents reported seeing a spiritualist. Therefore we did not use this measure of alternative resources in the analysis.

Related to integration into informal networks, we measured respondents' integration into the community by asking about their membership in voluntary associations such as churches, clubs, and school organizations. We constructed an index of the total number of positive responses to these questions. This was not significantly related to utilization of mental health services among any of the ethnic groups and is therefore not included in the tables showing the results of our analysis.

With respect to cultural barriers, the survey includes information related to the person's migration background: the number of years in the U.S. (for those born in Puerto Rico) and the age at which the person entered the U.S. to settle permanently. Respondents were also administered Cuellar's acculturation scale[19] which taps four dimensions of adherence to Hispanic culture: Spanish-language use and preference,

Table 3.3

Use of Mental Health Services, According to Grouped Number of Demoralization Symptoms Reported and Ethnicity. In percentages.

	Number of Demoralization Symptoms			
Ethnicity	0-1	2-7	8 or More	Total
Hispanics				
Reported emotional problems	12	18	45	25
Needed services				
Received	8.5	13	30	17
Not received	0	2	7.5	3
Not needed	3 5	3	7 5	5
Did not report emotional problems	88	82	55	75
Total number (=100%)	(61)	(67)	(66)	(194)
Blacks				
Reported emotional problems	3	17	39	15
Needed services				
Received	3	4	6	4
Not received	0	0	6	1

Ethnicity	Number of Demoralization Symptoms							
	0-1		2-7		8 or More		Total	
Not needed		0		13		27		10
Did not report emotional problems	97			83		61		85
Total number (=100%)	(38)			(24)		(18)		(80)
Whites								
Reported emotional problems	13			13		67		17
Needed services								
Received		5			0		33	6
Not received		0			0		17	1
Not needed		8			13		17	10
Did not report emotional problems	87			87		33		83
Total number (= 100%)	(40)			(23)		(6)		(69)
All Ethnic Groups								
Reported emotional problems	9			17		16		21
Needed services								
Received		6			9		26	12
Not received		0			1		8	2
Not needed		3			7		12	7
Did not report emotional problems	91			83		54		79
Total number (= 100%)	(139)			(114)		(90)		(343)

Note: Use of physicians' services excluded from computations.

preference for the Hispanic cultural heritage (food, music, Spanish-language media), cultural identification, and the ethnic groups the person associates with. The number of years in the U.S. had low correlations with the acculturation score and the age at which the person settled in the U.S., suggesting that each reflects a separate aspect of acculturation. Therefore we constructed an acculturation index composed of the three measures.

To obtain measures of cultural barriers towards use of mental health services, respondents were administered 11 vignettes, based on the Star vignettes,[20] about hypothetical persons with different types of emotional problems. Respondents were asked to rate the seriousness of each problem and whether the person described should seek help. Their responses were constructed as two separate indices, one of seriousness and another one on the appropriateness of help-seeking for these types of problems. Hispanics had significantly lower seriousness and help-seeking scores than blacks or whites, although the differences in magnitudes of the scores between Hispanics and the other groups were not large (less than one point difference out of a possible 11 points, between Hispanics and the others). In our analyses, we used indices of seriousness and help-seeking for the five vignettes in which Hispanics had significantly lower scores than the other groups. The indices are based on the vignettes for the following behaviors: menopausal disturbances, extreme anxiety, compulsive behavior, workaholic behavior, and religious visions. With respect to institutional barriers, we asked respondents about the frequency with which they experienced 18 common problems in seeking and receiving services from local agencies, for example, lack of attention by agency personnel, inability of personnel to speak Spanish, and having to make many appointments before being served. We computed an index of frequency of experiencing these problems.

As indicated in the discussion of Table 3.3, we used two measures of need for mental health services: the total number of reported demoralization symptoms and acknowledgment of having emotional problems. While the questions about self-reported emotional problems was included to get information about use of mental health services, our analysis showed this variable to be interesting in itself. The Demoralization Scale asks respondents to report symptoms without labeling these as emotional problems. The self-report question asks respondents whether they are aware of having had an emotional problem. Thus the two questions provide an interesting contrast between symptoms and awareness of symptoms. Using the above measures, we conducted separate analyses of the use of mental health services among Hispanics, blacks, and whites. These are presented below separately for each group.

Posited as a model, our analysis' objective was to determine the influences on utilization of alternative resources and of cultural

barriers, controlling for the individual's need for services. In the case of mental health services, need is defined as the number of symptoms reported in the mental health scale. Ideally, if no factor is associated with under- or overutilization, the only factor predicting utilization would be need: the greater the need, the more likely the use of mental health services. To the extent, then, that a factor is positively or negatively related to utilization after controlling for its relationship with need, that factor may be said to predict overutilization or underutilization. Based on the underutilization literature, we hypothesized that underutilizers were more likely to be found among those Hispanics who are unacculturated and recent immigrants, among those who have a greater number of friends, relatives, and neighbors providing help with different types of problems, and among those who report the most problems with service agencies.

We examined the relationship between utilization and variables indicative of the above factors, as well as the relationship between utilization and basic demographic and socioeconomic characteristics, number of distress symptoms reported, and acknowledgment of having an emotional problem. Table 3.4 shows the Pearson correlations between factors in the model and use of mental health services. Our utilization measure excludes reliance on a non-psychiatric physician. The majority reported using only one service. Thus, utilization is treated as a dichotomous variable in the analysis. The correlations show acknowledgment of emotional problems and psychological distress to be the most strongly and significantly related to utilization. Other variables significantly related to utilization are the acculturation index and living in an intact family, but the correlations are lower. The correlations shown in Table 3.4 seem to show little support for the alternative resources and barriers explanations of utilization. Moreover, the high correlation between acknowledgment and use of services suggests that becoming aware of symptoms might be synonymous with accepting the need for help, and thus seeking it.

The correlations in Table 3.4 also suggest the possibility that the nature of the control variable — psychological distress — explains the low predictive power of the alternative resources and barriers variables. Using mental health services and being psychologically distressed are relatively rare phenomena. In a sample of a resident population, it would be expected that the majority would not be psychologically distressed or use mental health services. Since the sample is fairly small, the fact that relatively few respondents would have high scores in the Demoralization Scale or use mental health services might explain why so few variables would have a strong relationship with utilization. We reasoned that seeking help for emotional problems might have meaning only for those with a high number of demoralization symptoms, those most likely to need help. Therefore, we divided the sample into low, medium, and high distress groups, predicting that the factors

Table 3.4

Correlations Between Selected Indicators of Factors in the Model and Use of Mental Health Services, Hispanics [N=217].

Factors	Mean	S.D.	Pearson R
Social Network Characteristics			
Index of help from social network members	2.2	1.2	-.05
Total number of persons mentioned	4.6	9 6	-.02
Frequency of contact with members of social network	7.7	5.6	.02
Index of membership in voluntary associations	1.1	1.8	-.06
Cultural Barriers			
Index of seriousness in mental illness vignettes	4.2	2 3	-.03
Index of help seeking in mental illness vignettes	3 3	1.3	.03
Acculturation index	.9	1 0	14**
Institutional Barriers			
Index of problems with agencies	1.6	2.4	06
Demographic Characteristics			
Age	43 1	16.7	.04
Years of education	8.7	6 8	- 01
Sex: female	8	.4	.11**
Family income	7922	7209	-.09***
Lives:			
in intact family	.29	.46	-.21*
in female headed family	39	.49	.15**
alone	.16	.36	.06
with other than relatives	16	.37	.00
Need for Mental Health Services			
Acknowledgement of emotional problems	.24	43	71*
Total number of demoralization symptoms	4.3	8.9	38*
Mean			.26
S.D.			65

Significance of T: * Less than .01; **.01 - .05; ***.06 - .10.

in the model would show relationships with utilization only among the high distress group.

A problem in dividing the sample into high and low psychological distress groups is the lack of empirical benchmarks indicating the number of symptoms in the Demoralization Scale which differentiate a

clinical from a normal population. This problem is compounded by the fact that, for cultural reasons, different ethnic groups may have different cut-off points in the scale. Some studies hypothesize that Hispanic cultural norms permit freer expression of mental illness symptoms, while Americans may be more reticent about revealing such symptoms.[21] Differences in the number of reported symptoms between Hispanics and other ethnic groups may reflect the effects of cultural influences. Askenazy[22] compared Hispanics, blacks, and whites in the social desirability that they ascribed to demoralization symptoms, and found that Hispanics rated these symptoms as more desirable than the other groups. As discussed in the Appendix, we found that Hispanics rated the symptoms less desirable than the other ethnic groups, although the differences in scores are not statistically significant. Using a more direct approach to this problem, Dohrenwend and associates are now investigating the mean number of symptoms reported by Hispanics, blacks, and whites clinically diagnosed to have different types of mental illnesses. Their research, not yet completed, will establish the cut-off points for clinical pathology among a sample of the general population. In the absence of these benchmarks, we divided the sample into terciles of numbers of reported symptoms — one or no symptoms, two to seven symptoms, and eight or more symptoms — as we did in Table 3.3 when examining utilization according to degree of psychological distress.

Table 3.5 shows the correlations between variables and utilization among respondents in each of the three symptom groups. Across all symptom groups, acknowledgment has the most consistent and strongest effect on use of mental health services. We found notable differences by symptom groups in the effects on utilization of alternative resources and barriers variables. Among the lowest symptom group, the total number of persons in the network and the index of frequency of contacts are negatively related to utilization, as would be predicted by alternative resources theory. Among the higher symptom groups, however, the size of the social network and the index of frequency of contacts are positively related to utilization. The number of reported symptoms is also related to the effects of institutional and cultural barriers variables. As predicted by barrier theory, among the lowest symptom group the index of frequency of problems with agencies is negatively related to utilization. However, among the middle symptom group, the index of problems with agencies has no effect on utilization, while among the highest symptom group, it is positively related to utilization. The acculturation index has the highest correlation with utilization among the middle symptom group; among the other two groups, the index is positively related to utilization but the correlations are not significant. We found no relationship between utilization and the measure of cultural attitudes towards mental illness. Therefore, these variables were not included in subsequent analysis.

These findings strongly suggested the possibility of interaction between demoralization — the number of reported symptoms — and variables indicative of alternative resource and the subcultural aspect of barrier theory. Interaction refers to a situation where the relationship between two variables is conditional upon the level of a third variable. For example, the correlations suggested that when psychological distress is low, members of the social network provide alternatives to use of mental health services, but when psychological distress is high, the symptoms override the help offered by members of the social network as an alternative to professional help. To test this interpretation, we conducted multiple regression on utilization of variables reflective of the hypothesized interaction between demoralization and variables in the model. For the reader unacquainted with the logic of multiple regression analysis, we precede the discussion of analysis findings with a brief description of multiple regression analysis and interaction.[23]

Multiple regression is a statistical technique for determining the relationship between an independent and a dependent variable after controlling for — taking into account — the possible effects that other independent variables may exert on the relationship between the two variables. To take a simple example, one may examine in multiple regression the effects of social network size on utilization of mental health services — the dependent variable — controlling for the influence of acculturation on social network size. Multiple regression allows one to determine the relative strength of association between the dependent variable and each independent variable. Multiple regression also allows one to determine the interrelationships among independent variables by showing the relative strengths of the direct and indirect effects independent variables exert on the dependent variable. To use the example above, one could hypothesize that those with small social networks are more likely to use mental health services than those with larger social networks. However, the acculturated may also have smaller social networks than the unacculturated, and this may have an influence on the relationship between social network size and utilization. Multiple regression would allow us to determine the relative strengths of the influences of acculturation on utilization — its direct influence and the influence it may exert on social network size and other variables which themselves may have an effect on utilization.

The test of interaction involves entering into multiple regression an interaction term — a variable composed of the hypothesized interacting variables — together with the variables that comprise the interaction term. A case for interaction can be made when adding the interaction term helps to explain more of the total variation in the dependent variable. Using this criterion, we found interaction between demoralization and the size of the social network, the index of frequency of contacts, and the index of problems with agencies. Of

Table 3.5

Correlations Between Use of Mental Health Services Among Hispanics and Indicators of Factors in the Model, According to Grouped Number of Demoralization Symptoms Reported.

Factors	Number of Demoralization Symptoms 0-1	2-7	8 or more
Social Network Characteristics			
Index of help	08	-.02	.03
Total number of persons mentioned	-.20***	.31*	.30*
Frequency of contacts with network members	-.18***	26**	.10
Membership in voluntary associations	-.01	-03	-.08
Cultural Barriers			
Index of seriousness in mental-illness vignettes	.07	.07	-.14
Index of help-seeking in mental-illness vignettes	.11	-.06	.09
Acculturation index	06	16	.04
Institutional Barriers			
Problems with agencies	-.17***	.16	.26**
Demographic Characteristics			
Age	-07	04	.03
Years of education	10	-13	.14
Sex: female	16***	04	.02
Family income	08	-12	.19**
Lives:			
in intact family	-13	-.19***	-.18***
in female-headed family	05	18***	.03
alone	05	.01	.11
with other than relatives	07	00	00
Need for Mental Health Services			
Acknowledgment of emotional problems	78*	81*	.64*
Total number of demoralization symptoms	-11	17***	.34*
Number of Services Used			
Mean	09	15	47
S D.	35	40	.81
N=	(61)	(67)	(66)

Significance of T: *less than .01; **.01-.05; ***.06-.10.

these, the interaction between demoralization and the size of the social network was the most powerful in terms of its effect on utilization. The index of frequency of contacts also interacts with demoralization, but its interaction term is not as strong as that of size of the social network. Moreover, although the size of the social network and frequency of contacts are conceptually distinct, we found a high correlation (r=.62) between the two. Therefore, in our analyses we included only the interaction term for demoralization and size of the social network. We also found evidence for interaction between demoralization and the index of problems with agencies. This suggested that among the lowest symptom group, having problems with agencies is associated with not using services, while among those with serious psychological distress, having problems with agencies is associated with utilizing mental health services. A more realistic interpretation of this relationship is to view problems with agencies among the psychologically distressed as an index of consumer satisfaction rather than as barriers to the use of mental health services. Those who use services apparently have more concrete knowledge of what services consist of, and are more likely to answer questions about services with specific experiences in mind. In Chapter 6 we examine problems with agencies from the perspective of satisfaction with services received.

Having found evidence of interaction between demoralization and the size of the social network, the next step in the analysis was to determine what other variables, together with the interaction term, influenced use of mental health services among Hispanics. In this and subsequent analyses, the variables considered reflect the logic of assessing the applicability of alternative resources and cultural barriers to the use of services. Variables relevant to each explanation were entered together into regression to determine which one had a stronger effect. If other variables such as demographic characteristics correlated significantly with utilization of the service in question, these variables' interrelationships with alternative resource or cultural barrier variables were also examined. We excluded acknowledgment of emotional problems from the regressions. This variable has such a high correlation with utilization that including it reduces the effects of the other variables to non-significance. Moreover, acknowledgment tends to have the same relationship with the other explanatory variables as utilization: the same factors explaining utilization in the discussion below explain acknowledgment of emotional problems. Thus, in the discussion of the analysis, it should be noted that acknowledgment of emotional problems is an additional and powerful factor in the use of mental health services.

A review of the correlations in Table 3.4 shows that in addition to social network size — which we have seen to interact with demoralization — acculturation, family income, and being female are positively associated with utilization, while living in an intact family is negatively

associated with utilization. The results of analysis indicated that in addition to the interaction term, acculturation and living in an intact family have significant effects on utilization. However, the influences of family income and gender are rendered non-significant when we take into account the influences of the other variables.

The influence on utilization of living in an intact family suggested the possibility of an alternative resource effect. Intact families may provide members with more support than other families and thus its members may feel that they do not need the help of professionals. The analysis revealed an interesting relationship between acculturation and living in an intact family: each variable's influence is masked by the effect of the other. The acculturated are more likely to use mental health services while those living in an intact family are less likely to do so. However, because acculturation and living in an intact family are positively correlated, controlling for the influence of each variable increases the influence of the other.

The regression results indicated that three variables — acculturation, living in an intact family, and the interaction term for demoralization and social network size — have significant influences on utilization, with the greatest influence shown by the interaction term. The analysis indicates that social network integration is conducive to use of mental health services only among the highly demoralized. It should be noted that the social network effect contradicts the alternative resources hypothesis, since integration into the social network is positively associated with utilization. We refer to this point later in the discussion. In addition, acculturation in conjunction with living in other than an intact family influences use of mental health services. An important finding is that these relationships are applicable only to those with serious psychological distress. To verify this, we examined the influence of factors in the model separately for three groups of respondents classified according to the degree of psychological distress. The sample was divided into terciles of number of symptoms — one or no symptom, two to seven symptoms, and eight or more symptoms — as shown in the correlations in Table 3.5. We discuss the influences of alternative resources and barriers variables first among the low symptom group, followed by the middle symptom and the high symptom groups.

Table 3.5 showed that among those with the lowest number of symptoms, the size of the social network was negatively related to utilization, as predicted by the alternative resources hypothesis. In line with the institutional barriers hypothesis, the index of problems with agencies was negatively related to utilization. In this group being female is positively related to utilization. Besides acknowledgment of emotional problems, no other variable, including demoralization, showed significant correlations with utilization. The regression analysis indicated that when the interrelationships among these variables are

taken into account, none of these variables has a significant effect. An important reason for this is the little variation in the dependent variable. Since only 10 percent of respondents in the low symptom group used mental health services, it would be expected that the factors in the model would exert little influence on utilization. However, the analysis results suggested that with a bigger sample, significant effects of the alternative resources and barrier variables might emerge. We speculate that among those with low psychological distress, anticipation of experiencing problems with agencies and resorting to the help offered by members of the social network influence Hispanics not to seek mental health services.

Next we examined the effects of alternative resources and cultural barriers among the middle symptom group, those reporting between two and seven symptoms. Table 3.5 showed that in this group, the size of the social network and living in a female-headed household were positively related to use of services, while living in an intact family was negatively related to use of services. In this group, acculturation is positively associated with utilization, but the correlation is not significant. We considered the possibility that the effects of acculturation were masked by its interrelationship with living in an intact family as was the case with the analysis of the entire Hispanic sample. The results indicated that acculturation is still not significant when we control for living in an intact family. When we examined the influences of the size of the social network, living in an intact family, and the number of reported symptoms, the size of the social network had the only significant influence on utilization. Similar results are obtained if we substitute living in a female-headed household for living in an intact family. Low variation in utilization among this group may also account for the little influence of the variables. As among those with one or no symptom, only a small proportion — 17 percent — of the middle symptom group use mental health services. However, in this group, social network integration is associated with using mental health services.

In line with our hypothesis that demoralization conditions the relationship between factors in the model and utilization, the most interesting results emerged when we examined the influences of alternative resource and cultural barrier variables in the group with the most pyschological distress, those with eight or more symptoms. Table 3.5 showed that in this group, the size of the social network is positively related, living in an intact family is negatively related, while acculturation is not related to utilization. We found that the size of the social network and the number of demoralization symptoms had positive and significant effects. This suggested that, in part, members of the social network provide advice and referral information because the effects of psychological distress make this need apparent as the number of symptoms increases.

It will be recalled from discussion of the regression analysis for the entire Hispanic sample that acculturation has a significant effect when we control for its interrelationship with living in an intact family. That effect was not found in the lower symptom groups, but it is striking among the high symptom group. When the effects of acculturation and living in an intact family are considered in conjunction with size of the social network and demoralization, all variables have significant effects on utilization. Because acculturation is associated with living in an intact family, the effect of acculturation on use of mental health services is strongest among those not living in intact families, while the tendency of those living in intact families not to use services is strongest among the unacculturated. The size of the social network directly influences utilization, but this is due in part to the effect that psychological distress has in making emotional problems apparent to members of the social network. Taking these influences into account, the greater the number of demoralization symptoms, the more likely the use of services.

Our findings provide support for the theory that cultural barriers reduce the use of mental health services among Hispanics. However, the influence that living in an intact household has in reducing utilization also suggests a possible role for alternative resources. If living in an intact household reflects the mutual support of spouses, or the support of parents toward children, Hispanics living under this type of family arrangement may be less likely to use mental health services, especially if in addition they are unacculturated. Conversely, acculturated Hispanics are more likely to use mental health services when they do not have the supports reflected in living in an intact household. For other members of the social network, an alternative resource function is not evident. On the contrary, members of the social network facilitate utilization of mental health services by providing advice and referral information when Hispanics manifest symptoms associated with mental illness. Leaving aside the influences of alternative resources and cultural barriers, the Pearson correlations in Table 3.4 show that acknowledgment of emotional problems has the strongest influence on use of mental health services. Acknowledgment tends to have the same relationships with the other variables as utilization does.

Utilization by Blacks and Whites

Turning now to the other ethnic groups' use of services, we find some similarities among Hispanics, blacks, and whites with respect to the factors associated with use of mental health services. As among Hispanics, for blacks and whites acknowledgment of emotional problems plays the most important role in seeking mental health services. As among Hispanics, social network characteristics have some influence on the use of services among blacks; while no influence is shown by those measures indicative of problems with agencies and beliefs about mental illness. We first examine use of services among blacks and then

Table 3.6

Correlations of Factors Associated with Use of Mental Health Services, Blacks [N = 87]

Factors	Mean	S.D.	Pearson R
Social Network Characteristics			
Index of help	2.5	1 4	21**
Total number of persons mentioned	4.4	3 4	.09
Frequency of contacts with network members	7 0	5 5	09
Cultural Barriers			
Index of seriousness in mental-illness vignettes	4 4	2 1	11
Index of help-seeking in mental-illness vignettes	3 3	1 6	.11
Institutional Barriers			
Problems with agencies	1.1	1 6	.35*
Demographic Characteristics			
Family income	7675	8099	.16**
Age	49	19	-.20**
Lives:			
in intact family	24	43	00
in female-headed family	25	.44	.12
alone	36	48	-.05
with other than relatives	15	.36	- 09
Need for Services			
Acknowledgment of emotional problems	16	37	50*
Total number of demoralization symptoms	2.0	8 4	-.11
Number of Services Used	05	21	—

Significance of T: *less than .01; **.01-.05, ***.06-.10.

among whites.

Table 3.6 shows the Pearson correlations between factors in the model and use of mental health services among blacks. The table shows that among social network characteristics, only the index of help from members of the social network is associated with use of services. However, as was the case among Hispanics, this variable predicts utilization opposite to the expected direction. Members of blacks' social networks appear to provide referral information and advice which lead to the use of professional help.

As among Hispanics, the data do not show evidence for the influences of cultural barriers on the use of mental health services among blacks. Blacks' beliefs about the seriousness of mental illness cases described in the vignettes and the frequency of problems they have with agencies have no effect on use of mental health services. The vignettes variables show little correlation with use of services, while problems with agencies are associated with using rather than not using services. As suggested in our examination of Hispanic utilization, the data on problems with agencies are a more valid indicator of satisfaction with services than of institutional barriers.

Among demographic variables, age is negatively related and family income is positively related to use of services. The former is in contrast to the case of Hispanics, where the oldest are the most likely to use mental health services. Acknowledgment of emotional problems is the variable most strongly correlated with use of services. As is the case with Hispanics, this is an important factor which we did not include in multivariate analysis because its high correlation with utilization reduces the influences of other factors to non-significance. Among blacks, the total number of symptoms reported is not significantly correlated with use of services.

The Pearson correlations in Table 3.6 show that three variables are significantly associated with use of mental health services among blacks: family income, age, and receiving help from members of the social network. In multiple regression analysis, we examined the interrelationships among these variables. Because the number of cases and the magnitudes of the correlations are small, the regression results do not meet the criteria for statistical significance. However, they suggest that age and receiving help from members of the social network influence use of mental health services, while the influence of income on utilization is accounted for by the fact that older blacks have lower incomes than younger ones. With respect to this, it will be recalled that a high proportion of elderly blacks, a subgroup overrepresented in the sample, have incomes below the poverty level. Once the influence of age on income is accounted for, income level does not directly influence use of mental health services among blacks. Although the regression results are not statistically significant, they suggest a similar role for the social network as was found among Hispanics. Those who are integrated into the social network are the most likely to make use of services through the help of referrals and advice from members of the social network.

Table 3.7 shows the correlations between factors in the model and use of mental health services among whites. Among this group, there are no significant correlations between measures of social network integration and utilization. As among blacks and Hispanics, measures of problems with agencies and of beliefs about mental illness are not related to use of services. Unlike among blacks, family income and

other demographic characteristics show no relation to use of services. Only one demographic variable, relying on work as an income source, is negatively related to use of services. Since the whites are older, this suggests that those whose main source of income is Social Security, which includes Medicare, are more likely than others to make use of mental health services. However, when the income source variable is entered into regression with other factors, it becomes non-significant.

Table 3.7

Correlations of Factors Associated with Use of Mental Health Services, Whites [N = 77]

Factors	Mean	S.D.	Pearson R
Social Network Characteristics			
Index of help	2.6	1 3	13
Total number of persons mentioned	4 7	2 6	- 06
Frequency of contacts with network members	8 5	5 3	04
Cultural Barriers			
Index of seriousness in mental-illness vignettes	5.7	2 3	07
Index of help-seeking in mental-illness vignettes	4 4	9	- 03
Institutional Barriers			
Problems with agencies	1 6	1 7	04
Demographic Characteristics			
Age	56 6	20 8	04
Family income	12730	12965	03
Lives:			
in intact family	48	50	- 11
alone	31	46	10
with other than relatives	14	35	07
Work is main income source	3	5	- 17***
Need for Services			
Acknowledgment of emotional problems	2	4	52**
Total number of demoralization symptoms	4 4	5 2	15***
Number of Services Used	05	22	—

Significance of T: *less than .01; **.01-.05, ***.06 10.

As with the other ethnic groups, acknowledgment of having emotional problems is the most strongly related to utilization. Thus, for whites, analysis yields only negative conclusions: neither alternative resource theory nor the subcultural aspect of barrier theory is applicable to utilization of mental health services.

Summary

Examining utilization of mental health services among Hispanic, black, and white residents of a South Bronx area, we find that even among residents with a high number of psychological distress symptoms, the majority do not seek mental health care. When we control for the relationship between psychological distress and other factors in our model, some factors show a strong effect on utilization. In all ethnic groups, those who acknowledge emotional problems are the most likely to use mental health services. This relationship is independent of the effects of social network integration, acculturation, or other characteristics of respondents.

Our data provide some evidence for the influence of cultural barriers on the use of mental health services. Acculturated Hispanics are more likely than the unacculturated to use mental health services. With respect to institutional barriers, our data show that perceptions of having problems with agencies, instead of indicating barriers to use of services, predict utilization. We interpret this finding to indicate that those who use mental health services are more knowledgeable about how these services are rendered and are thus more likely to be critical of them. The hypothesis of institutional barriers would be better tested by directly measuring characteristics of agencies posited to be related to utilization.

The findings also bring up questions of how barriers are experienced by prospective help-seekers. The theory assumes that knowledge and attitudes about services are diffused by those who have used services to those who have not, and that the latter decide not to seek these services on the basis of what they hear. It may also be that those seeking services have personal experiences with service providers which stop them from continuing seeking of services. While our data show that users of mental health services have more negative attitudes than non-users, the questions we asked are not precise enough for us to determine through which of the mechanisms posited above institutional barriers function. At any rate, our findings have been useful in refining our conceptualization of how institutional barriers may act as obstacles to utilization.

Besides the relationship between living in an intact family and not using mental health services, our data provide no evidence that for those with serious psychological distress, integration into the informal web of friends, neighbors, and relatives provides an alternative to mental health care. Among Hispanics and blacks, indices of social

network integration have significant effects on utilization, but in a direction opposite to that hypothesized by alternative resource theory. Integration into the social network provides advice and referral information which increase the possibility of seeking services. However, although the relationships are not strong, the data also suggest that for those with a low number of symptoms, integration into the social network provides an alternative to use of mental health services, and perceptions of problems with agencies act as barriers to use of services. This suggests that the degree of psychological distress qualifies the influences of alternative resources and institutional barriers on the use of mental health services. In Chapter 7, we consider the implications of the findings, which are of relevance to the ways in which agencies may reach potential users of their services.

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27 A more detailed presentation of the multivariate analyses with corresponding tables is available upon request from Orlando Rodriguez, Hispanic Research Center, Fordham University, Bronx, New York 10458.

4

SERVICES FOR FEMALE HEADS OF FAMILY

The concept of utilization has been applied for the most part to issues of health and mental health. The previous chapters cited a large literature on the utilization of mental health services by Hispanics, but we find few empirical studies that address the issue of utilization of other than health services. While few social scientists and practitioners conceptualize social services as being under- or overutilized, the idea of utilization would seem clearly applicable to services other than mental health or health. The objectives of this and the next chapter are to examine the utilization of social services among important subgroups of residents of our study area. This chapter examines the use of services among female heads of family, and the next chapter focuses upon the use of services by the disabled and the elderly. Generally speaking, services for the disabled and the elderly have different objectives than services for female heads of family. For the most part, services for female heads of family aim to maintain families at acceptable levels of economic well-being or to improve their economic status, while services for the other groups aim to correct disadvantages stemming from old age or disability.

Like other depressed areas, the Fordham-Tremont area has higher than average unemployment and poverty rates. Female heads of household are among the most numerous of service-eligible residents in the area. One-third of all households in the sample — 43 percent of Hispanic households, 29 percent of black households, and 5 percent of white households — are headed by a female with children. The high rates of minority female-headed households in our study area underscore a major issue that we explore in this chapter: the role of job training programs and other services in helping minority group women to seek employment as an alternative to public assistance.[1] This chapter begins with a brief review of the literature on utilization of social services. We then examine the extent to which women's experiences in forming a family and raising children, as well as their previous employment experiences, influence their use of job training programs and related social services. We also examine the extent to which

alternative resources and cultural barriers are applicable to the use of social services among Hispanic and black female heads of family.

Literature on Utilization of Social Services

In contrast to health and mental health studies, research on Hispanic patterns of utilization of social welfare services is relatively rare. Social welfare includes a mix of services aimed at improving the lives of low-income people. All these services fall under the mandates of various government agencies, for example, day care, Head Start, vocational rehabilitation, services for the elderly, job training, and adult education. Cash grants under the various income maintenance and benefits programs are treated separately below.

The Office of Human Development Services (OHDS), U S Department of Health and Human Services, conducted a survey of Hispanic participation rates in OHDS programs based on participation data supplied by state OHDS program officials. Participation was measured by means of a simple parity ratio: the percentage of Hispanic participants in a given state's program divided by the percentage of Hispanics in the state's population in need of services. Overall, the study found that Hispanics represent 13.3 percent of participants in OHDS programs and 17.1 percent of those who are in need of services, for a parity participation rate of 77.9 percent. Parity percentages were particularly low in vocational rehabilitation, and Title XX, that is, programs for children, youth and families, while parity was over 100 percent for programs for elderly.[2]

The OHDS study's findings of differences by states are noteworthy. The higher the percentage of Hispanics in the state, the higher the participation ratio Moreover, the states with high participation ratios were predominantly Mexican American, while Florida (predominantly Cuban) and New York (predominantly Puerto Rican) had low participation ratios. The only exception to the pattern is Illinois, with low participation and Mexican American predominance. These findings contradict the utilization patterns suggested by mental health studies, viz., that Mexican Americans are more likely to underutilize mental health facilities than Puerto Ricans. These differences may reflect differences in types of needs between Puerto Ricans and Mexican Americans, or differences in the institutional locus of barriers to service, or subcultural differences among the two groups, but existing studies cannot tell us which of these factors operate to cause these contrasting patterns. They are noted here as another instance of Hispanic diversity.

With respect to Hispanic utilization of social mobility services — employment, training, and adult education programs — few data are available. For example, Morgan reviewed barriers to Hispanic women's participation in New York City job training programs and found that there was no basic information on Hispanic participation in local Head

Start, day care, the Work Incentive (WIN) Program, basic adult education, and other programs.[3]

The 1980 *Employment and Training Report to the President*[4] provides national-level information on characteristics of individuals in job training programs. Of the 1,675,992 individuals enrolled under the now defunct Comprehensive Employment and Training Act (CETA) programs in fiscal year 1979, 43 percent were white, 42 percent were black, 11 percent were Hispanic, and 4 percent were classified as "other" — presumably Native Americans and Asian Americans. Over 90 percent of participants were economically disadvantaged, unemployed, underemployed, or not in the labor force, and over 80 percent came from families with yearly incomes of less than $7,000. These characteristics were evenly distributed among all ethnic groups, except for the higher proportion of blacks with yearly incomes of less than $7,000 among youth program participants. Minority youth were also unevenly accepted into different youth programs. Among white youth of either sex, roughly two-thirds were enrolled in youth training programs such as the Youth Employment Training Program or the Youth Community Conservation and Improvement Projects, and one-third were enrolled in the Summer Youth Program, which entails less than three months' participation and is generally believed to provide little actual occupational training. In contrast, among black youth of either sex, over half of participants were enrolled in the Summer Youth Program. Half of Hispanic males and one-third of Hispanic females participated in the Summer Youth Program, while one-third of other minority males and over half of other minority females were in the Summer Youth program. If we take enrollment in programs other than the Summer Youth program as an indication of participation in actual job training programs, white youth were the most likely to be assigned to such services, black youth were the least likely, and Hispanics and other minorities stood between blacks and whites.

These figures do not tell us how equitably individuals of different ethnicity in the population are represented in CETA programs. To do so we must compare the number of individuals of different ethnic groups with their cohort in the population eligible for job training. We estimated participation rates in CETA youth training programs of different sex and ethnic groups, using as a base first all youth in the population and then all youth below the poverty line. Summer Youth Program participants were excluded from these estimates. The base for estimating the total population cohorts is the number of youth aged 16 to 21 and the subset of that cohort whose families were below the poverty line, according to the March 1977 Current Population Survey (CPS) computer data file. The participation rates are consequently higher than if we had used the 1979 population as a cohort base, but differences among ethnic groups should not be distorted by the use of 1977 figures. The definition of economically disadvantaged in the

CETA data is roughly similar to the poverty level cut-off in the March 1977 CPS.

Table 4.1 shows that government job training programs for youth reach a minute portion of all youth in the population, and less than 15 percent of all economically disadvantaged youth in the population. The low rate suggests that many more youth could be served than there are slots for. While not all economically disadvantaged youth wish or need job training, the impression is that most job training programs report having to turn away applicants. This suggests that participation rates in the 1970's were too low. If anything, the need is greater under current government policies, which have substantially reduced job training expenditures.

Whites underutilized job training programs in comparison to minorities, but differences in participation rates among ethnic groups

Table 4.1

Estimates of Participation Rates in CETA Training Programs (Except Summer Youth) by All Youth 16 to 21, and by Youth in Families Below the Poverty Level, by Sex and Ethnic Group

	Rates per 1000 Population			Rates per 1000 Below Poverty Level		
Ethnic Group	Male	Female	Both	Male	Female	Both
Whites	11	12	11	143	104	120
Blacks	53	61	57	170	148	157
Hispanics	37	38	37	143	139	141
Other minorities	51	41	46	286	156	207
All groups	19	20	20	155	124	137

were small. The differences were narrowed when we controlled for the numbers of their respective populations in need of job training, as indicated by poverty status. Under this criterion, differences in participation between white youth and minorities were narrowed. Economically disadvantaged black youth utilized job training programs less than other non-Hispanic minorities, but more than Hispanic youth. However, the difference between the highest and lowest utilization groups was less than 10 percent, suggesting a fairly equitable distribution of job training slots among ethnic groups. An examination of job training participation rates among older individuals suggested a similar range of narrow differences in participation among whites and minority group members.

Participation in public assistance programs, in food stamps and medical benefit programs, and in supplementary income and benefits programs fits within an examination of Hispanic utilization of services. Prevailing stereotypes to the contrary, the poor tend to underutilize these services. For example, Gordon estimated that in 1969, 42 percent of eligible New Yorkers did not receive public assistance,[5] while a New York City Rand Institute study in 1976 estimated that 48 percent of welfare-eligible recipients did not receive public assistance.[6] People eligible for public assistance may forego benefits for the same reasons they do not seek health or other social services: lack of knowledge, stigma attached to seeking of services, and organizational barriers in applying for services.[7]

An earlier version of the New York City Rand Institute study cited above[8] subdivided the percentages of non-recipients among welfare-eligibles according to ethnic groups, and found that Hispanics have higher utilization rates than either blacks or whites: 74.3 percent of Hispanic, 64.9 percent of black and 34.6 percent of white-welfare eligibles were enrolled in public assistance programs. The ethnic order of participation remained the same after controlling for such socio-demographic factors as numbers of female-headed families, numbers of elderly and non-elderly adults, age of family, and family size. By this criterion, all groups in the city underutilize public assistance, but in this instance Hispanics utilize it more than others.

Some conclusions may be derived from this brief review of studies of utilization of social services. It is clear that we lack systematic knowledge about patterns of utilization of social services among the different Hispanic minorities. Even in the areas of health and mental health services, existing research is hampered by divergent definitions of utilization and the restriction of studies to Mexican Americans and Puerto Ricans. This chapter's objective is to determine the extent to which Hispanic and black female heads of family in the South Bronx utilize occupationally oriented and other types of social services, and to examine the influences on the use of services of factors associated in previous research with the use of social and mental health services.

Utilization Patterns

We asked women about their need for and use of six services: job training, placement in the Work Incentive Program (WIN — a job training and placement program for people receiving public assistance), adult education, parent-child counseling, day care, and public assistance. Table 4.2 shows the percentages of Hispanic and black female heads of family who reported needing and receiving each of the above services. Because there were only four white female heads of family in the sample, our analysis focuses only upon black and Hispanic women. The table shows a striking contrast in both groups between the use of public assistance and the use of other services. Four-fifths of Hispanic

women and three-fourths of black women reported needing public assistance and all but a few reported receiving it. These percentages are higher than those reported in official statistics for public assistance enrollment among eligible female-headed households in New York City in 1975. However, those data refer to the city as a whole, while ours are for one of the lowest income areas in the city. It is also notable that one-fourth of women report not needing public assistance. In the majority of cases, these women were receiving other types of benefits instead, for example, survivors' benefits. In a few households, other household members such as older sons or daughters brought in income from work. It seems safe to assume that in the absence of these other supports most women in the sample would be receiving public assistance.

Table 4.2

Need for and Use of Services Among Hispanic and Black Female Heads of Family. In percentages.

Services	Hispanics		Blacks		Both Groups	
Job Training						
Needed	17		28		19	
Received		3		12		5
Not received		14		16		14
Not needed	83		72		81	
Total number (=100%)	(94)		(25)		(119)	
Placement in WIN Program						
Needed	21		20		21	
Received		4		0		3
Not received		17		20		18
Not needed	79		80		79	
Adult Education						
Needed	21		12		19	
Received		3		4		3
Not received		18		8		16
Not needed	79		88		81	
Day Care						
Needed	5		12		7	
Received		2		12		3
Not received		3		0		4
Not needed	95		88		93	
Parent-Child Counseling						
Needed	13		8		12	
Received		9		4		8
Not received		4		4		4
Not needed	87		92		88	

Continued on next page

Services	Hispanics	Blacks	Both Groups
Public Assistance			
Needed	84	76	82
Received	83	76	81
Not received	1	0	1
Not needed	16	24	18
No. of Total Services Needed & Used (Excluding Public Assistance)			
None	64	68	64
One	10	4	8
Two	4	4	4
Three	22	24	24
Total number (=100%)	(94)	(25)	(119)
Received fewer services than needed	76	75	75
Total number (=100%)	(34)	(8)	(42)
No. of Total Services Needed & Used (Including Public Assistance)			
None	11	16	12
One	51	48	50
Two	12	8	12
Three	26	28	26
Total number (=100%)	(94)	(25)	(119)
Received fewer services than needed	33	29	32
Total number (=100%)	(84)	(21)	(105)

Of the non-financial services inquired into, job training and adult education were the most needed and used, while fewer needed day care and family counseling. Approximately one-fifth of Hispanic women reported needing job training or placement in WIN, and of these, most did not receive it. A greater proportion of black women were able to receive job training than was the case among Hispanic women. One-fifth of black and Hispanic women reported needing adult education, and among these the majority did not receive this service. Smaller proportions of women reported needing day care or family counseling and those needing them were more likely to receive them than those needing job training or adult education. Comparing the proportions needing and receiving services, job training and adult education are the most underutilized services, while greater proportions of those women reporting needs for family counseling and day care actually receive these services. Nevertheless, it is striking that so few women reported

needing job training and adult education. We explore this issue in our analysis of the findings.

Table 4.2 summarizes the women's needs for and use of all services. Excluding public assistance, one out of three female heads of family report needing at least one service. If public assistance is added, nine out of ten females report needing at least one service. Virtually identical proportions of black and Hispanic heads of family report needing services. Excluding public assistance, three-fourths of the women regardless of ethnicity reported receiving fewer services than needed. If public assistance is included, one-third of Hispanic and black women report receiving fewer services than needed. It is clear that many women in the area would like to receive more services than they do now. These figures indicate substantial underutilization of services by female heads of family.

In Chapter 3 we examined the utilization of mental health services in the light of two competing explanations —alternative resources theory and the subcultural aspect of barrier theory. In turning our attention to the utilization of social services, the relevance of these two theories must be considered. The need for social services like job training is not equivalent to the need for health services. In the latter, the aim is to prevent or correct some personal imbalance. On the other hand, the aim of social services — other than counseling and other health-oriented services — is to maintain or promote a minimum of physical or economic well-being, i.e., to enhance the physical environment or improve the employability of an individual. While economic well-being and health are closely intertwined, the objectives for offering and the motivations involved in seeking each type of service are different. Thus, it is pertinent to question the relevance of alternative resources and cultural barriers for an understanding of the utilization of economically oriented social services.

Alternative resources theory maintains that the family, friends, and neighbors act as sources of help alternative to the help provided by mental health professionals. It is possible to conceive of social networks as providing a similar function with respect to economic exchange. Anthropologists have long pointed to the multiplicity of exchanges of goods and services among the poor.[9] In the context of U.S cities, however, these exchanges may be more properly seen as supplemental to public assistance and the labor market. Individuals may rely on family members and others for income and job opportunities, but it is difficult to see their relying on these because of rejecting institutional source of economic help. We therefore hypothesize that for female heads of family, the social network provides information and advice rather than an alternative to the use of economic services. The richer the social network, and the more integrated the woman is into it, the more likely she will make use of job training and the other services.

Barrier theory seems more clearly applicable to an understanding of factors associated with the use of services among Hispanic female heads of family. Institutional barriers, such as the lack of Spanish-speaking personnel in service agencies, or cultural barriers, such as low acculturation, may discourage Hispanics from using job training services in the same way that they may discourage them from seeking mental health services. Therefore, we hypothesize that the more acculturated, the more likely the person is to receive job training and occupationally related services. With respect to these services, acculturation, more than involving an orientation to American culture, may involve knowledge of how American society functions, for example, that job training services may be available to those who qualify.

We indicated above that organizational characteristics of service agencies may influence the readiness of individuals to seek services. The mental health utilization literature has suggested that factors such as the availability of Spanish-speaking personnel and their cultural sensitivity influence the readiness of Hispanics to seek help from agencies. Such a process may also be expected to take place among those seeking job training and other occupationally related services. Our data are individually based and thus contain no information on the organizational characteristics of agencies in the study area. Furthermore, as we saw in Chapter 3, our measure of individual perceptions of institutional barriers, the index of perceived problems with agencies, does not predict underutilization. We find the same with respect to female heads of family: those who use services are the most likely to report problems with agencies. Positive correlations are also found between the indices of problems with agencies and the use of other services.

Our analysis focuses upon other factors we believe particularly relevant to use of services among female heads of family: previous work experience and child-bearing decisions. Since labor force participation is influenced by previous work experience,[10] we include in the analysis the female's previous work experience in the country of origin and in the United States. Work experience in each country is treated as an index. In the country-of-origin work experience index, the lowest value is assigned to those who have not worked either in the U.S. or the country of origin, or who were under the age of 17 at the time of immigration; those who have worked in both countries are assigned the highest value. Intermediate values are assigned to those who have sought work or have worked in either country. With respect to work in the U.S., one variable measures the number of years of employment and another treats work experience as an index. In the U.S. work experience index, the lowest value is assigned to never having worked, intermediate values are assigned to having worked in the past and having worked recently, and the highest value is assigned to currently holding a job. It would be expected that the less extensive the work

experience, the more likely the woman would be to receive job training. However, the labor market research literature suggests that early work experience is related to later success in the labor market.[11] The same may be applicable to use of job training services. We hypothesize that the more extensive the work experience, the more likely to use job training services. We also hypothesize that adult education and day care — services that can help those who must leave the household to work — are most attractive to women with extensive work experience. With respect to family formation decisions, we included in the analysis the age at which the female bore the oldest child and the age of the youngest child. We hypothesized that the younger the female when she had her first child, and the younger her children, the less extensive her work experience and, therefore, the less likely to use job training and adult education. However, we expected that women with older children would not be interested in day care regardless of their work experience.

Relevant to examining the applicability of alternative resources and cultural barriers, our analysis also included the measures of social network integration and acculturation used in the analysis of use of mental health services, and measures of perceived needs for services. We indicated earlier that, unlike the need for health services, it is difficult to obtain an objective measure of need for social services. Need and use are not completely independent, since those who report not needing a service do not use it. However, Table 4.2 shows that three-fourths of female heads of family received fewer services than needed, excluding public assistance. Thus, perceived need for a service is a factor in receiving it, but other factors must be taken into account. Our analysis aimed to determine how the factors in our model influenced perceptions of need for services and, in turn, the use of services.

In our analysis below, we examine first the females' use of job training services, followed by analysis of the use of day care, adult education and family counseling. The use of job training combines reports about use of two services: placement in the WIN program and use of other types of job training programs. We view day care and adult education as services that help occupational advancement, although we recognize that they may be sought for other reasons. We also examine the use of family counseling services, although we are aware that this service is the least related to services oriented to economic improvement. Separate analyses are conducted for Hispanic and black females.

Utilization by Hispanics

Table 4.3 shows the correlations between variables in our model and the use of each of the services among Hispanic female heads of family. It will be recalled that the social network variables — our measures of alternative resources — measure several dimensions: types of help (with heavy home chores, with personal problems, etc.), the number of social

network members, and the number of instances of help from different types of relations (friends, relatives, associates, etc.). As in Chapter 3, we used three indices of social network integration: the index of help received, the total number of persons in the social network, and the frequency of contacts with members of the social network. We also included in the analysis an index of membership in voluntary associations such as clubs, churches, etc. With two exceptions, Table 4.3 does not show significant correlations between these indices and use of services, thus providing no support for the alternative resources hypothesis.

Table 4.3 supports the notion that cultural barriers reduce women's access to services. Among measures of cultural barriers, the acculturation score is positively associated and the age at which the person settled in the U.S. is negatively associated with use of some services. Another measure of acculturation, the number of years in the U.S., is not significantly related to use of services. When these variables are combined into an index, the latter's correlation with use of services is weaker than the correlation of the acculturation score. Therefore, in the analysis below we use the acculturation score rather than the index of the three variables. Acculturation is associated with use of job training services, but is not related to use of other services. We will see in the discussion of the multiple regression analyses below that acculturation, while not directly related to use of some services, influences the relationship between other factors and utilization. The data in Table 4.3 do not support the institutional barriers hypothesis. The correlations between perceptions of problems with agencies and use of services are not negative, as the institutional barriers argument would indicate. Therefore, we do not include the measures of problems with agencies in the analysis below.

Table 4.3 shows that having previous work experience is associated with the use of services. Work experience is positively related to use of job training services, although having worked in the country of origin is negatively related to use of job training services. Our multiple regression analysis explores the reasons for this unexpected relationship. Work experience is also related to use of adult education, but it is not related to use of day care, and is negatively related to use of family counseling services.

We hypothesized that family formation would influence the women's labor force participation and thus, indirectly, their use of job training services. With the exception of family counseling, Table 4.3 shows no significant correlations between use of services and the age at which the woman bore her oldest child, or the age of the youngest child. Finally, the table shows a strong correlation between perception of need and use of services. We also find that receiving public assistance is not related to use of job training, even though one form of job training (WIN) is available only to those on public assistance. This suggests that

Table 4.3

Hispanic Female Heads of Family (N=94) Correlations Between Variables and Use of Job Training Services, Adult Education, Day Care, and Family Counseling

Factors	Mean	S.D.	Pearson Correlations: Job Training	Adult Education	Day Care	Family Counseling
Social Network Characteristics						
Index of help	2.6	1.3	-.04	-.13	.22*	.08
Total no. of persons mentioned	3.4	2.4	.02	-.04	.00	.13
Frequency of contacts with network members	8.0	5.4	.03	-.01	-.03	-.04
Membership in voluntary associations	.9	1.9	-.07	.09	-.11	.20**
Cultural Barriers						
Acculturation score	1.9	.7	.28	-.05	-.12	-.11
Institutional Barriers						
Problems with agencies	1.6	1.8	.05	.11	.28	.17***
Work Experience						
In country of origin	2.9	3.9	-.21*	.19	-.09	.16***

Factors	Mean	S.D.	Pearson Correlations: Job Training	Adult Education	Day Care	Family Counseling
In U S.	9	8	19*	07	04	- 02
Recency of working or seeking work (positive = most recent)	38 5	46 5	17*	04	- 08	- 22**
Family Formation						
Age at which bore oldest child	23 3	6 2	04	- 07	- 07	- 07
Age of youngest child	11 5	8 4	13	- 06	- 14	- 25*
Demographic Characteristics						
Age	37 3	12 5	- 05	- 06	- 12	01
Years of education	8 8	3 2	28	03	- 06	- 02
Family income	5993	3362	00	- 09	17	03
Number of years in current residence	2 2	8	13	- 04	- 13	01
Services Needed						
Job training	6	1 0	32			
Adult education	21	41		34		
Day care	05	23			62	
Family counseling	13	34				80
Mean			07	03	02	09
S.D			26	18	15	28

Significance of T: *less than .01; **.01-0.5; ***.06-.10.

the women reject job training for reasons other than the income benefits derived from public assistance.

We conducted multiple regression analysis to examine the interrelationships among factors in the model and the use of services by Hispanic female heads of family.[12] We first discuss analysis of the use of job services and continue with the use of other services. As in the analysis in Chapter 3, the objective is to examine the influences of variables indicative of competing explanations of utilization: alternative resources and cultural barriers. With respect to the use of services for female heads of family, an additional objective is to examine the influences of previous work experience and family formation.

Table 4.3 shows that acculturation is associated with use of job training services, while variables indicative of social network integration are not significantly related to use of this service. In terms of the influences of factors in the model, the data support the cultural barriers explanation and not the alternative resources explanation. The data also show that work experience is associated, while family formation is not associated with use of this service. A puzzling aspect of the correlations in Table 4.3 was the lack of a relationship between the woman's age of child bearing and use of job training services. When we examined the correlations we found that — contrary to expectations — the more acculturated and educated the women, the less likely to have delayed the age of child bearing. We found a very high positive correlation (r=.83) between the woman's age and the age of bearing the first child, indicating that older women started having children later in the life cycle than younger women. Since older women were the most likely to have spent their formative years in Puerto Rico and the other countries of origin, this suggested that generational differences induced by the migration experience affected child bearing decisions. It may be that when faced with the decision to have the first child, the older generation women faced economic obstacles which delayed their child bearing. Older generation women are less acculturated and less educated. Holding these relationships constant, the age at which the woman decided to have her first child has an important influence on participation in job training. The analysis reveals interesting differences between younger and older generation women. The older generation women were the most likely to delay child bearing, which exerts a positive influence on use of job training, but their lower levels of acculturation and education exert opposing influences on use of this service. Younger women are less likely to delay child bearing, but their higher levels of education and acculturation counteract the influences of their decisions about when to have children.

Another unexpected finding of Table 4.3 is the fact that work experience in the U.S. is positively related to use of job training services, but work experience in the country of origin has the opposite effect. We found that work experience in the country of origin does not influence

use of job training services when other variables related to the work experience are considered. Women who worked in the country of origin are older, less educated, and less acculturated, and these three factors are negatively associated with participation in job training. Controlling for the interrelationships between these three factors and work experience in the country of origin renders non-significant the influence of work in the country of origin.

The analysis indicated that acculturation, work experience in the U.S., the age of bearing the first child, and education each have strong and significant influences on the use of job training. The analysis also suggested that acculturation, while indirectly influencing use of job training through its influences on education, family formation, and work experience, also has a direct effect on use of job training.

Table 4.3 also showed that perception of need is related to use of this service. We hypothesized that the relationship would be explained by the influences of the other variables on perceived need. We expected that after controlling for the influences of acculturation and the other significant variables on perception of need, the direct influence of this variable would be substantially reduced. We found that the direct effect of perceived need did not disappear, but it was reduced by its interrelationships with the other variables. Acculturation, previous work experience and education separately contribute to reduce the influence of perceived need.

To summarize the analysis, we found that the following factors influence the use of job training among Hispanic female heads of family: acculturation, education, delaying child bearing, and having worked previously. Acculturation directly influences the use of job training, but it also indirectly influences the use of this service through its relation with education and, to a lesser extent, through its effect on perception of need for job training. In comparison to the indirect effects of acculturation, we found that work experience, education and delaying child bearing more directly influence use of job training services.

Turning now to the use of other services, we first discuss factors associated with the use of adult education programs. Since we saw education and the other services as being related to the same socioeconomic objective as job training, we hypothesized that the factors applicable to job training would also be applicable to use of the other services. Table 4.3 showed that among social network characteristics, only the index of help is related to the use of adult education. Acculturation is not significantly related to the use of this service. Work experience in the country of origin is associated, but no other index of work experience is significantly correlated with use of this service, and neither are variables related to family formation decisions.

In examining the use of adult education, we considered the possibility that acculturation might indirectly influence use of this

service through its effects on education or previous work experience, as was the case with respect to use of job training. However, the analysis did not confirm our hypothesis. We also considered the possibility that the influences of family formation on use of adult education might be indirect. For example, it could be that controlling for age and education, women with older children would have less difficulties and more interest in using adult education programs. However, the regression results did not show this to be the case. Perception of need is associated with use of this service, but no other factor reduces the effect of perception of need. Independently of this, work experience in the country of origin is related to use of this service, but other factors that might explain this effect — for example, age and acculturation — do not account for the influences of work experience in the country of origin. In sum, the data do not throw light on which factors influence use of adult education.

Examining factors associated with the use of day-care services, it may be noted from Table 4.3 that the index of help from members of the social network is positively related to the use of day care. The indices of acculturation and of work experience are not related to use of day care; and surprisingly, the youngest child's age is also not related. Table 4.3 also shows that family income is positively associated with, and length of time of residence in the neighborhood is negatively associated with use of day care. However, these variables' influences are not significant when one takes into account the age of the youngest child or the index of help from members of the social network. Therefore they were not included in the analysis. As with use of other services for female heads of family, Table 4.3 showed a high correlation between perception of need and use of day care.

We considered the possibility that interrelationships between help from members of the social network, the age of the youngest child, and acculturation might influence the use of day care. For example, controlling for the age of the youngest child could increase the influence of help from the social network; or acculturation could indirectly influence use of day care if it also influenced receiving help from members of the social network. The analysis indicated that only the help index has a strong and significant effect. Neither acculturation nor the age of the youngest child indirectly influences use of day care. However, when we consider the influence of perceived need, the effect of the help index is not statistically significant. We surmise that those who perceive a need are more likely to seek the help of members of the social network in seeking information about day care. In sum, contrary to the assumptions of alternative resources theory, integration into the social network is associated with use of day care. There is no evidence that cultural barriers or previous work experience influence use of this service.

Although service providers in our study area indicated that family counseling is an important service for female heads of family, the service is more relevant to mental health issues than the other services surveyed in this chapter. Therefore we expected that previous work experience would not be a relevant influence, while alternative resources, cultural barriers, and family formation would be more relevant to the use of this service. Reviewing the correlations in Table 4.3, it may be seen that among social network characteristics, membership in voluntary associations is positively related, while previous work experience is negatively related to the use of this service. Women with older children are more likely than those with younger ones to use this service, perhaps reflecting family problems associated with adolescence. It may also be noted that there is a high correlation between perception of need and use of this service.

Because previous work experience in the country of origin is associated with low acculturation, we considered the possibility that controlling for work experience in the country of origin might bring into relief the influence of acculturation on use of family counseling. The analysis results did not support this hypothesis. Thus, the data do not show the influence of cultural barriers on use of this service.

We also considered that the interrelationship between membership in voluntary associations and the age of the youngest child might explain use of family counseling. Membership in churches and parent-teacher associations are common among women with young children. Women with adolescents may be more likely than women with younger or older children to belong to parent-teacher or other types of associations, and this could explain the influence of voluntary association membership. On the other hand, women with adolescent children who belong to churches may have available sources of referral that nonchurchgoers may not have. Controlling for the relationship between the age of the youngest child and membership in voluntary associations, the only significant effect is that of membership in voluntary associations. Thus, the relationship between the age of the youngest child and use of this service is due to the fact that women with older children are more likely to belong to voluntary associations that facilitate use of this service. Finally, we saw in Table 4.3 that there is a high correlation between perception of need and use of family counseling. This effect is not explained by the influences of other variables on perceived need.

To summarize the analysis results, the data indicate that cultural barriers reduce access to job training by Hispanic female heads of family. Lack of previous work experience and forming a family early in life also reduce Hispanic women's access to job training. The data provide no evidence that Hispanic female heads of family use their social networks as alternatives to the help provided by professional agencies. On the contrary, integration into a social network is associated with the use of some services. For all services, perception of need is

strongly associated with utilization. Acculturation indirectly influences use of job training through its effect on perception of need for job training. With respect to use of other services, we did not find that the factors in the model influence utilization by their effect on perception of need.

Utilization by Blacks

We now turn to an examination of factors associated with the use of services by black female heads of family. Table 4.4 shows the correlations between use of services and variables in our model. We first examine the use of job training services, followed by adult education, day care and use of family counseling services. Because the total number of respondents is small (N=25), our discussion is limited to the findings suggested by examination of Pearson correlations and partial correlations, that is, correlations between utilization and one variable controlling for the effects of a third variable on the other two.

As in the case of Hispanic female heads of family, Table 4.4 shows that for black females social network integration is associated with the use of services, rather than with providing alternatives to use of professional agencies. Social network indices are significantly correlated with use of job training and day care, but there is no relationship between these indices and use of the other services. As was the case among Hispanic female heads of family, previous work experience is correlated with the use of job training services. This supports the hypothesis that women with the most extensive work experience are the most likely to make use of job training services. Unlike the case with Hispanic women, factors related to family formation, for example, delaying the age of child bearing, have no effect on the use of training services. Below we examine how interrelationships among social network integration, previous work experience, family formation, and perception of need influence use of job training. With respect to use of the other services, the correlations in Table 4.4 do not warrant examination of the interrelationships among factors in the model.

Table 4.4 shows that the index of frequency of contacts with social network members, the extent of previous work experience, and perception of need are positively related to use of job training by black female heads of family. Contacts with social network members and previous work experience independently influence use of this service. Controlling for the effect on either variable, the other's correlation is reduced but significant. For example, the Pearson correlation between use of job training and frequency of social network contacts is .37, but its partial correlation, controlling for the indirect influence of previous work experience, is .34. Frequency of contacts and previous work experience also indirectly influence use of job training through their effect on perception of need. When the former are taken into account,

Table 4.4

Black Female Heads of Family (N=25) Correlations Between Variables and Use of Job Training Services, Adult Education, Day Care, and Family Counseling

Factors	Mean	S.D.	Pearson Correlations Job Training	Adult Education	Day Care	Family Counseling
Social Network Characteristics						
Index of help	3.0	1.3	.30***	.01	.09	-.01
Total no. of persons mentioned	3.7	3.8	.17	.02	.21	.02
Frequency of contacts with network members	7.0	4.9	.37	.20	.37**	.16
Membership in voluntary associations	2.0	.9	-.12	.01	.16	.24
Institutional Barriers						
Problems with agencies	.8	1.2	.32	.46	.50	.46
Labor Force Experience						
Number of years of employment	9.1	21.5	.64	.00	-.15	-.10
Index of work experience	.8	.9	-.09	-.14	.22	.39
Family Formation						
Age at which bore oldest child	22.0	6.5	-.19	.17	-.15	.00
Age of youngest child	8.7	5.7	-.26	-.18	-.17	-.10
Demographic Characteristics						
Age	33.8	11.7	-.18	.14	-.13	-.07
Years of education	13.[illegible]	15.7	-.09	-.20	.00	.25
Family income	5442	2630	-.10	-.15	.25	.48*
Services Needed						
Job training	.5	.8	.32			
Adult education	.12	.33		.55*		
Day care	.12	.33			1.0	
Family counseling	.08	.27				.69*
Mean			.12	.04	.12	.04
S.D.			.33	.2	.33	.2

ficance of T: *less than .01; **.01-0.5; ***.06-.10.

the effect of perception of need is not significant. For example, the Pearson correlation between use of job training and perception of need (.32) is reduced to .12 when controlling for the influence of frequency of contacts with social network members. Controlling for previous work experience yields similar results. We considered whether the influence of family formation might be masked by its interrelationship with previous work experience, as was the case among Hispanic women. This is not the case. Controlling for previous work experience, there is no relationship between delaying child bearing and use of job training.

Summary and Conclusions

Because of low income, a disadvantaged position in the labor market, and problems in raising children in an inner-city setting, female-headed families require many social services. With the exception of use of public assistance, female heads of family receive fewer services than they report needing. In particular, job training and adult education are underutilized among Hispanic women, although black women also report receiving fewer of these services than they need.

We examined the utilization of services by women in the light of alternative resources and cultural barriers. We also explored the influences of work experience and family formation in the use of services by these women. In line with the cultural barriers hypothesis, for Hispanic women acculturation directly influences use of job training but has no influence on use of other services. In the case of job training, acculturation also indirectly influences utilization through its effect on delaying family formation and on perception of need for that service. Our analyses lead to the conclusion that alternative resources theory is not applicable to the use of social services, particularly services aimed at economic improvement, among female heads of family. Although we found no evidence for alternative resources, the social network, which forms the basis of the alternative resources argument, does have important influences in the use of some services. Social networks help in gaining access to social services by providing information and advice about these services. Using various indicators of social network integration, we found that the more integrated into a social network, the more likely the woman is to make use of social services. For both groups, when the social network influences use of a service, it functions as a source of referral information and advice, rather than as an alternative to use of professional agencies. We believe this finding to have important implications for the way social services are organized in areas like the South Bronx. In Chapter 7 we will argue that social programs could become more effective by making use of women's social networks.

Our analyses examined the effects of low acculturation to determine whether it acted as a barrier to the use of social services. The data show direct and indirect influences of acculturation on use of some services. In line with the cultural barriers hypothesis, for Hispanic women

acculturation directly influences use of job training but has no influence on use of other services. In the case of job training, acculturation also indirectly influences utilization through its effect on delaying family formation and on perception of need for that service. The data also show that lack of work experience, low education and bearing children early in life together act as barriers to the use of job training services. Thus, those most likely to benefit from these services are the least likely to receive them. Our data suggest that job training programs and other programs whose objectives are to improve the economic situation of minorities may have to examine their intake processes to determine whether their procedures bar the most needy from access.

Among Hispanic women, previous work experience directly influences the use of job training services, but has no effect on the use of day care, adult education, or family counseling services. Among black women, previous work experience is strongly related to use of job training services, but is not related to the use of other services. This suggests that those most likely to benefit from services geared to occupational advancement are the least likely to get them, pointing to the need for occupationally oriented services to consider how to serve those in highest need of their services and perhaps refocus their programs to make them more attractive to those with little work experience and education.

Women's decisions about family formation also influence the use of some services. Among Hispanic women — but not among black women — delaying child bearing influences the use of job training services, after controlling for the interrelationship between work experience and the age of bearing the oldest child. The age of the child influences use of family counseling among Hispanic women. Women's decisions about family formation may also have to be taken into account by job training and other programs concerned with the occupational advancement of female heads of family.

Perception of needs for services is an important factor in the use of all services. It is less important to the use of job training and adult education than to the use of other services. We expected that factors in our model would explain the influences of perceptions of need. This is the case with respect to use of job training among black and Hispanic women, but for the other services, perception of needs is not influenced by the other factors in the model. Thus, we assume that other factors not taken into account in our model influence the relationship between perception of needs and use of services.

Utilization theory views organizational characteristics of agencies as potential barriers to use of services by Hispanics. We indicated above that our data, being individually based, have no measurements of the organizational characteristics of the many agencies providing services in the area. We also saw that, insofar as perceptions of problems with

receiving or seeking services indicate organizational barriers, there is no evidence for barriers to use of services. On the contrary, those who use services are the most likely to report problems with agencies. We draw the conclusion that our measure of perceptions of problems measures consumer satisfaction rather than barriers to use of service. This brings up an important consideration for barrier theory. It may be that organizational characteristics such as lack of Spanish-speaking personnel, rather than discouraging seeking of services, may discourage continued use of services. We discuss the policy implications of this finding in Chapter 7.

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5

SERVICES FOR THE DISABLED AND THE ELDERLY

In this chapter we examine the use of services by Hispanic, black and white disabled and elderly residents of the Fordham-Tremont area. For obvious reasons, the disabled and the elderly are particularly vulnerable to the stresses of life in a modern society and require special services which others can obtain on their own. Simple facets of life such as shopping, cleaning, cooking and getting around are problematic to many elderly and disabled people. The elderly and disabled also face special health and human services problems which agencies must address, as the Older Americans Act of 1965 and specific acts of legislation for the disabled recognize.

Very little information is available from census or other types of data on the distribution of physical and other types of disabilities among ethnic groups. The New York State Governor's Advisory Committee of Hispanic Affairs reports that less than 1 percent of New York State's population has some type of developmental disability, that is, a physical or mental handicap.[1] Applying this estimate to New York's Hispanic population, the report estimates that there are 12,000 Hispanics with developmental disabilities, pointing out that according to New York State's service statistics, no more than one-fifth are receiving services. However, the report does not state how the estimates of disability are compiled, or what kinds of physical or mental conditions are included under the category of developmental disability.

More information is available on characteristics of the elderly Hispanic population. The Hispanic population of the U.S., as well as that of New York City, is younger than other population groups. Nevertheless, the Hispanic elderly will be growing rapidly in the next few decades. Approximately one-fifth of New York City's population is over the age of 60, but 11 percent of the black population and 7 percent of the Hispanic population are in the same age range.[2] Approximately 7 percent of the Bronx population is also elderly, and a similar percentage of the general Puerto Rican population falls into the same category.[3] In the Fordham-Tremont area, census estimates indicate that 5 percent of the Hispanic population, 8 percent of the black population, and 31 percent of the white population are over the age of

60. This shows that in comparison to the rest of the Bronx and New York City, the Fordham-Tremont area has a higher than average concentration of elderly whites and a lower than average concentration of minority elderly. This is useful to keep in mind when we examine interethnic patterns of use of services among the elderly in the area. Census data underscore the fact that minority elderly are at higher risk, and therefore more needy of services than the white elderly. For example, 1980 Census data show that among those 65 years of age or older, 14 percent of whites, 38 percent of blacks, and 31 percent of Hispanics were below the poverty level.[4]

As in other inner-city areas, agencies in the Fordham-Tremont area try to make use of limited resources to provide as many services as possible for their elderly and disabled populations. This chapter examines how black, white and Hispanic elderly and disabled people in the Fordham-Tremont area use some of these services. As in examinations of other services, we consider the applicability of alternative resources and cultural barriers to the use of services by these group We begin with analysis of use of services by the disabled and then focus upon services for the elderly.

The Disabled

Literature on Utilization of Services for the Disabled

There is little information on the prevalence of disabilities among ethnic groups in the population, and little in the research literature that may be used as a guide to how disabled Hispanics and others use services. Because the term disability covers a broad range of physical and mental handicaps, it is difficult to gather comprehensive and systematic information on the numbers in the population who suffer from different types of physical infirmities or mental disabilities such as retardation, chronic mental illness or substance abuse. Disabilities are difficult to ascertain through survey data, since they often require the expert judgment of professionals. Research on disabilities focuses upon specific disabilities, some of which (like mental illness) are the subject of specific subdisciplines. While one may find articles on deafness, blindness, and other types of disabilities, the findings from one field may not be translated into those of other fields; and in general, ethnicity is not a focus in research on the disabled.[5]

Utilization Patterns

In our survey we asked respondents about a broad range of disabilities, using as a criterion the respondent's judgment that the complaint prevented him/her or another household member from carrying out housework, work, or school activities. Approximately one out of four households — 24 percent of Hispanic, 26 percent of black, and 17 percent of white households — report having one (in some cases

more than one) disabled person. This seems to indicate a high proportion of disabled people in the area. Table 5.1 shows the types of disabilities reported by respondents in each ethnic group. Among the most common disabilities are (in descending order of frequency): paralysis or loss of limbs, arthritis, internal organ dysfunctions other than heart disease, substance abuse, hearing problems, and circulatory and heart problems. Since in our study disability was defined as a condition which in the view of the respondent prevented him or her from carrying out normal activities, it is unclear how many of the reported complaints are actual disabilities as would be defined by agencies for the disabled. Overall, disabilities related to sense and motor functions were the most commonly reported. White households were most likely to report these and Hispanic households the least likely. Substance abuse and mental illness were more frequently reported among Hispanic households than among the others. We

Table 5.1

Type of Disability, According to Ethnicity

Disability*	Hispanic	Black	White	All Groups
		Numbers		
Sight-related	2	2	2	6
Hearing-related	4	3	2	9
Motor function				
Arthritis	9	2	1	12
Paralysis, loss of limb	6	5	4	15
Internal function				
Circulatory	6	3	—	9
Other (asthma, etc.)	7	4	—	1
Mental retardation	4	1	2	7
Mental illness	3	—	—	3
Substance abuse	6	2	2	10
Epilepsy	3	—	—	3
Psoriasis	1	1	—	2
Total	51	23	13	87
		Percentages		
Sight/motor/hearing	41	52	69	48
Internal functions	33	34	—	29
Mental health and substance abuse	18	10	15	13
Mental retardation	8	4	15	10

*Missing answers deleted from computations.

believe that respondents significantly underreported substance abuse. Some of the disabilities reported, such as arthritis and circulatory system complaints, may refer to complaints associated with middle and old age; although it is recognized that chronic diseases such as asthma or arthritis may be as disruptive of people's lives as paralysis or hearing impairments. If we exclude arthritis and internal body function complaints, one out of seven households — 13 percent of Hispanic, 16 percent of black, and 15 percent of white households — have at least one disabled person. This is still a high proportion, indicating that physical and mental disabilities are a serious problem for families in inner-city areas.

No respondent in white households reported internal function disabilities in spite of the higher percentage of elderly in the white sample. It may be that whites were less likely to see their ailments as disabilities. On the other hand, most studies show that whites of all age groups tend to be healthier than minority individuals.[6] Therefore, whites in the sample may in fact have fewer disabilities. This interpretation is supported by the age distribution of the disabled in each ethnic group. Households with whites over 60 years of age were less likely to report having a disabled person (24 percent) than minority households (34 percent).

Respondents who indicated that there was a disabled person in the household were asked about that person's needs for and use of six services for the disabled: counseling for disability-related problems, vocational counseling, placement in employment programs for the disabled, special transportation services, state certification of disability which makes one eligible for vocational rehabilitation and Supplemental Security Insurance benefits, and financial assistance. Table 5.2 shows the percentages in each ethnic group reporting need for and use of each service, and summarizes each ethnic group's experience across all services, that is, the extent to which respondents received all or some of the services needed.

The most needed services among the Hispanic disabled are disability-related counseling, state certification of disability, and financial assistance. Among blacks, only a minority indicate a need for a specific service, with the greatest proportion needing transportation. Among whites, counseling is the most needed service, with two-fifths of this group also reporting a need for transportation, certification of disability, and SSI. Employment-related services appear to be the least needed. There is a notable contrast between Hispanics and the other two groups in perceived need for transportation. Hispanics have little interest in transportation, while among blacks and whites this is the most needed service. Transportation also appears to be the most difficult service to obtain in the area. Over 50 percent of the disabled who report needing transportation are unable to receive it.

About half of disabled Hispanics need counseling for disability-

related problems and state certification of disability. It is easier for Hispanics to receive counseling than it is to obtain certification. Three-fourths of Hispanics who need counseling obtain it, while half of those needing certification do not obtain it. Employment-related services are reported to be relatively unneeded by all ethnic groups, but Hispanics who need this service are the least likely to obtain it. Among Hispanics needing vocational counseling, over one-third were unable to obtain it, while seven out of ten who needed placement in special employment programs were unable to obtain it.

Of all services for the disabled, the financial assistance offered by SSI is the most widely utilized. Hispanics are more likely than blacks or whites to report needing this service, but this may be explained by differences between Hispanics and others in eligibility for SSI, and by other groups' reliance on alternative sources of income, such as social security and pensions not readily available to Hispanics. Among those who needed SSI, the majority received it, but in this case Hispanics are more likely to receive it than blacks or whites.

Table 5.2 summarizes the disabled's needs for and use of all six services surveyed. The table summarizes use of services first excluding and then including SSI in the computations. Seven out of ten disabled persons needed at least one non-financial service, with Hispanic and white households needing more services than black households. Including SSI, eight out of ten persons need services, with whites and Hispanics reporting more needs than blacks. Substantial numbers among the three ethnic groups receive fewer services than needed. Examining non-financial services first, half of the persons in each ethnic group receive fewer services than needed. While whites and Hispanics need more services than blacks, the disabled blacks who need services receive fewer than the other two groups. For example, 42 percent of Hispanics, 50 percent of whites, and 69 percent of blacks receive fewer services, including SSI, than needed.

Because in our study disability is self-reported, it may be that the estimates of use of these services may be too low. Among those reporting needs for these services there may be some who may not qualify according to the relevant agencies' criteria for defining disability. Some complaints like arthritis, poor circulation, and other internal body dysfunctions might lend themselves to more subjective definitions of disability than the other types listed in Table 5.1. We looked at the proportions of Hispanics needing and receiving each service according to two types of disabilities. The first group includes conditions commonly accepted to be disabling: physical and mental disabilities such as blindness or mental retardation. The second group includes conditions where the extent of disability is more questionable, for example, arthritis and internal body dysfunctions. Persons with disabilities of the first category were more likely to report needing and receiving services than those reporting disabilities of the second

Table 5.2

Need for and Use of Services Among the Disabled, According to Ethnicity. In Percentages.

Services	Hispanic		Black		White		All Groups	
Counseling About Disability Problems								
Needed	49		28		58		45	
Received		38		14		36		32
Not received		11		14		22		13
Not Needed	51		72		42		55	
Total number (=100%)	(54)		(22)		(14)		(90)	
Counseling About Job Training and Job Seeking								
Needed	15		9		14		11	
Received		9		9		14		7
Not received		6		0		0		4
Not needed	85		91		86		89	
Employment Services								
Needed	11		9		14		11	
Received		4		9		14		4
Not received		7		0		0		7
Not needed	89		91		86		89	
Special Transportation Services								
Needed	17		32		36		23	
Received		6		18		15		10
Not received		11		14		21		13
Not needed	83		68		64		77	

Services	Hispanic		Black		White		All Groups	
State Certification of Disability								
Needed	48		18		36		39	
Received		28		9		22		22
Not received		20		9		14		17
Not needed	52		82		64		61	
Financial Services								
Needed	67		27		36		52	
Received		62		23		29		47
Not received		5		4		7		5
Not needed	33		73		64		48	
Non-Financial Services Needed								
None	28		39		21		30	
One	30		39		14		30	
Two	22		17		50		25	
Three	20		5		15		15	
Received fewer services than needed	49		64		55		53	
Total number (=100%)	(39)		(14)		(11)		(64)	
All Services Needed (Including Financial)								
None	11		30		14		17	
One	30		35		21		30	
Two	24		26		36		26	
Three	35		9		29		27	
Received fewer services than needed	42		69		50		46	
Total number (=100%)	(48)		(16)		(12)		(76)	

Table 5.3

Disabled Hispanics (N=56): Correlations Between Variables and Use of Disability Counseling, Job Counseling, Employment for the Disabled, Transportation Services and State Certification of Disability

Characteristics	Mean	S.D.	Disability Couns.	Job Couns	Employ-ment	Transp.	State Cert.
Social Network Characteristics							
Index of help	2 3	1 3	- 21**	- 12	- 15	- 03	- 28**
Total number of persons mentioned	3 6	2 2	22***	- 17	- 16	- 32*	- 14
Frequency of contacts with social network members	7 8	5 3	06	- 25*	- 24*	- 20**	- 17
Cultural Barriers							
Acculturation index	8	1 1	16	22*	44*	- 02	02
Institutional Barriers							
Problems with agencies	2 2	2 7	15	- 11	07	10	.00

Characteristics	Mean	S.D.	Disability Couns.	Job Couns.	Employ-ment	Transp.	State Cert.
Demographic Characteristics							
Sex: male	14	35	-11	41*	20***	06	-02
Age	44 3	20 0	-20**	08	-21 *	16	18***
Years of education	6 8	3 8	08	17	32 *	02	10
Lives in							
Intact family	5	4	-02	25 *	11	-08	-16
Female-headed family	4	5	19**	03	06	03	14
Number of years in current residence	7 4	8 5	-20 *	12	20* *	-01	-05
Family income	7007	7925	-01	50	11	18***	-04
Income source is salary	04	19	05	28*	-04	03	-11
Need for Services							
Demoralization score	7 9	7 0	31	-20* *	-16	-20* *	00
Services reported needed							
Disability counseling	46	50	83*				
Job counseling	14	35		77			
Employment	11	31			56*		
Transportation	16	37				51*	
Certification	46	50					65*
Mean			38	09	04	43	27
S.D.			49	29	19	50	45

Significance of T: * Less than .01, **.01-.05; ***.06-.10.

category, but these differences were statistically significant (Chi-square .10 or less) only with respect to needing and receiving disability counseling, and only with respect to receiving placement in employment programs. It is particularly important that there are no significant differences between the two categories of disability in the proportions receiving state certification of disability. In the first group, one-third received state certification and in the second group one-fifth received certification. Therefore, we believe that respondents' self-definitions of disability are reliable.

Utilization by Hispanics

To consider the applicability of alternative resources and cultural barriers to the use of services by the disabled, we examined the influences of measures indicative of these factors on the use of services, first among disabled Hispanics and then among disabled blacks. We did not examine the use of services among disabled whites because of their small number in the sample. Table 5.3 shows the Pearson correlations between factors in the model and the use by disabled Hispanics of the following services: counseling about problems related to the disability, counseling about job training and employment, placement in employment programs for the disabled, transportation services, and certification of disability.

Focusing first upon the correlations between indices of social network integration and use of services, it may be seen that all but one significant correlation are negative. For disabled Hispanics, social network integration is associated with not using services, suggesting that members of the social network provide resources alternative to the use of these services. Some of the correlations provide support for the cultural barriers explanation. For example, the higher the acculturation index, the more likely to be placed in employment programs for the disabled. The variables that comprise the acculturation index — the acculturation score, the number of years in the U.S., and the age at which the person settled in the U.S. — also show significant correlations with use of services. This table and the table showing Pearson correlations between variables and use of services among disabled blacks do not show the correlations between use of services and the index of membership in voluntary associations, which is associated with the use of services among other subgroups. Correlations with this variable were not significant and therefore the variable was not used in the analysis below. As with the use of other services, we examined the effects on use of these services of perceptions of problems with agencies. Contrary to the institutional barriers hypothesis, perceptions of problems are associated with using, rather than not using these services.

We considered how age, education, family income, and other background characteristics are associated with using services for the disabled. These correlations are discussed below in the multilvariate analysis of each service. Finally, as we found for other services, reported need has the highest correlations of all factors with use of services. As would be expected, demoralization — a measure of need — is associated with using counseling for the disabled, but is negatively related to using job counseling and transportation. The latter correlations may not be contradictory. They may indicate that demoralized persons may not be in a good state of mind to make use of transportation services or job-related programs.

In our multiple regression analysis we examined the interrelationships among factors in the model and use by disabled Hispanics of disability-related counseling, training and job counseling, employment programs for the disabled, transportation, and certification of disability. Below we discuss the results and implications of the regressions examining use of each of these services.[7]

The correlations in Table 5.3 show that the index of help is negatively related, while the size of the social network is positively related to use of disability-related counseling. This was puzzling, since it showed two different functions of the social network at the same time: an alternative to use of services, and the provision of information and advice leading to use of services. The correlation between acculturation and use of this service is not significant. Younger persons, those most recently arrived in the neighborhood, those living in female-headed households, and the demoralized are the most likely to use disability counseling. There are plausible reasons for the relationships between use of services and age and demoralization, but it was not clear why living in a female-headed household or being recently arrived should be related to use of these services. However, the regression results indicated that the effects of these two variables were not significant and therefore they were excluded from the analysis.

The first step in our analysis was to determine why the size of the social network and the index of help act in opposite ways with respect to utilization. Because the size of the social network and degree of help are positively associated, controlling for each variable's influence increases the influence of the other. The most likely to utilize are those with large numbers of people in the network who receive little help, and the least likely to utilize are those with small networks who receive a lot of help. However, this does not explain why two aspects of the network work in different ways. We considered the possibility that acculturation indirectly influenced utilization through its effect on the characteristics of the social network. We hypothesized that the acculturated would rely less on informal help from network members and more from official agencies. This hypothesis was not confirmed. The acculturation index has no effect on the relationships between utilization and the social

network variables.

Since the youngest and the most demoralized are the most likely to use disability counseling, we considered the possibility that these variables influenced the relationship between social network integration and use of this service. However, controlling for age and demoralization increases the influences of the social network variables. For example, the oldest are the least likely to use this service, but older persons have larger social networks than younger ones. Holding age constant, the influence of social network size increases. We found that the relationship between perception of need for this service and the help received from the social network explains the influence of the social network variable. Holding perception of need constant, the effect of the help index is not significant, while the effect of size of the social network is significant. Since perception of need is not likely to influence the size of the social network, the analysis suggests that those who perceive a need for disability counseling turn to social network members for advice and information about seeking the service, while those who do not perceive such a need turn to the network for help as an alternative to that offered in agencies. This interpretation leaves unsolved the question of what factors account for perception of need for this service. Leaving aside the influence of perception of need, the analysis suggests that the social network is an important factor in use of this service — for some a source of advice and referral information, for others an alternative to professional counseling.

Turning now to factors associated with the use of job training and employment counseling among disabled Hispanics, the correlations in Table 5.3 show that the frequency of contacts with members of the social network is negatively related, while acculturation, family income, and employment as an income source are positively related to use of this type of counseling. Males and those living in an intact (two-partner) family are also more likely than others to use this service. When we analyzed the use of mental health services in Chapter 3, we found that living in an intact family influenced utilization. Therefore we considered the possibility that the interrelationship between living in an intact family and frequency of contacts with social network members might reduce the influence of the social network variable. The analysis indicated that living in an intact family does not reduce the influence of the social network variables on utilization.

We have seen that those reporting fewer contacts with social network members and the acculturated are the most likely to use job counseling. Since the most acculturated have the least frequent contacts with social network members, we considered whether acculturation indirectly influences utilization through this relationship. This would indicate the influence of cultural barriers on alternative resources. The analysis results indicate that the magnitude of the correlation between acculturation and frequency of contacts is not high enough to influence the

relationship between frequency of contacts and utilization. Because of this, in multiple regressions neither variable has a statistically significant effect on utilization. However, the regression results suggest that acculturation does not completely account for the alternative resource influence shown by the negative correlation between frequency of contacts and use of this service.

The analysis results show that, in addition to perceived need, being male and having a relatively high family income have significant effects on use of job counseling. Sex and family income partly influence perception of need. Those who perceive a need for job counseling do so partly because they are males and have relatively high family incomes. While the multivariate analysis showed no relation between acculturation and use of this service, the sex effect suggests the operation of cultural barriers, in the sense that Hispanics deem the use of the service to be more appropriate to males than females. Countering this suggestion, the next analyses do not show sex to influence use of employment services for the disabled.

Table 5.3 shows similarities between the effects of variables on use of job counseling and their effects on use of employment services. Among social network variables, the index of frequency of contacts is negatively related to use of this service, while acculturation is positively related. Among background characteristics, being male and relatively educated are positively related, while being older is negatively related to use of this service. With respect to use of this service, the analysis clearly shows that acculturation indirectly influences utilization through its effect on perception of need and on the frequency of contacts with social network members. Those who perceive a need use this service in part because they are the most acculturated, and those integrated into the social network are less likely to use this service because they are the least acculturated.

We next examine the use of transportation services among disabled Hispanics. The correlations in Table 5.3 show that the size of the social network and the frequency of contacts with members of the social network are negatively related to use of this service. The table also shows that family income is positively related and demoralization is negatively related to use of transportation services. It is not apparent why the demoralized are the most likely to use transportation. However, controlling for the influence on demoralization of social network size, demoralization has no effect. For reasons unexplained, the larger the social network, the more likely the person is to be demoralized. Holding constant social network size, demoralization has no effect on use of this service.

Since the indices of social network integration are negatively associated with use of transportation services, we first examined how their interrelationships influence utilization. The analysis indicated

that frequency of contacts is associated with use of this service because the larger the social network, the more frequent the contacts among social network members. Thus, the size of the social network directly and negatively influences use of transportation services and it influences use indirectly through its relationship with frequency of contacts with social network members. Although perception of need independently influences the use of transportation services, the size of the social network has a slight indirect influence on use of this service through its effect on perception of need.

Recalling from Table 5.3 that family income is positively associated with use of transportation services, we considered the possibility that higher income households might rely on transportation services requiring some contribution by the client, while lower income households rely on members of the social network as an alternative to transportation. However, the analysis showed that when family income is considered, the social network variable is still a significant influence on use of this service. In sum, there are three independent influences on use of transportation services: social network integration, which provides an alternative to use of this service; family income, which we assume makes this service more accessible; and perception of need, the effect of which is slightly reduced by its interrelationship with size of the social network. We interpret the analysis results to mean that members of the social network provide transportation to disabled Hispanics, or else bring to their households goods and services which others would have to obtain by means of transportation.

The correlations in the last column of Table 5.3 show the influences of factors in the model on the use of state certification of disability. As with use of other services, for disabled Hispanics social network integration is negatively associated with use of certification. Age and perception of need are positively associated, but acculturation or other variables do not have significant correlations with use of this service. The regression analysis indicates that the index of help and perception of need directly influence use of this service, but age does not significantly influence use of this service. The oldest are the most likely to perceive a need for this service, but regardless of age, perception of need is associated with using this service. Although perception of need has the strongest influence on use of this service, the analysis results suggest that to some extent receiving help from social network members negatively influences perception of need, thus indirectly influencing use of this service.

To summarize the results of the regression analyses: for disabled Hispanics, members of the social network provide alternatives to the use of professional services. To a lesser extent, social network members also offer help conducive to use of disability counseling. With respect to employment-related services, acculturation has an important influence, but not with respect to use of other services. As with other services we

examined, the person's perception of need has the most important influence on use of services, suggesting that other factors not accounted for in our model may influence utilization of these services. However, acculturation considerably influences perception of need for employment programs, and social network integration has a slight effect on perception of need for other services for the disabled. Thus, we find evidence that alternative resource theory is applicable to Hispanics' underutilization of services for the disabled. With respect to employment services, the cultural barriers hypothesis is also applicable.

Utilization by Blacks

Like Hispanics, disabled blacks report considerable underutilization of some services. Table 5.4 shows the Pearson correlations between factors in our model and use of services among disabled blacks. Because the numbers in the sample are too small (N=22) we limited the analysis to examination of Pearson and partial correlations. We used partial correlations to determine the extent to which explanatory variables indirectly influenced utilization. In the logic of partial correlation analysis, a reduction in the correlation between perceived need and use would indicate an indirect effect. For example, if the correlation between perceived need and utilization is reduced after we hold constant social network integration, this would indicate that the latter influences utilization indirectly through its effect on perceived need.

The correlations in Table 5.4 show that measures of social network integration are positively associated with use of two services: special employment and transportation. This suggests that, in contrast to disabled Hispanics, members of disabled blacks' social networks provide information referral and advice about using these services. As with the use of other services, perceptions of problems with agencies are either positively correlated or do not have significant correlations, indicating that problems with agencies do not represent institutional barriers to use of services for the disabled.

Some background characteristics show significant partial correlations with use of services. Disabled persons who live in households where the main income source is from jobs are more likely than others to receive counseling about disability-related problems and job training. Family structure is associated with use of services, but not in a consistent manner across services. For example, those who live alone are more likely than others to receive state certification of disability, but less likely to be placed in employment programs for the disabled. As we found with use of other services, perceived need has high correlations with use of services. As a measure of need, demoralization is positively related to use of transportation services — the opposite of what we found among disabled Hispanics. Contrary to expectations, demoralization is negatively related to use of disability counseling, again the

Table 5.4

Disabled Blacks (N=22): Correlations Between Variables and Use of Disability Counseling, Job Counseling, Employment for the Disabled, Transportation Services and State Certification of Disability

Characteristics	Mean	S.D.	Disability Couns.	Job Couns.	Employ-ment	Transp.	State Cert.
Social Network Charateristics							
Index of help	2 4	1 5	09	- 05	25	12	03
Total number of persons mentioned	5 2	5 0	- 24	- 22	72**	-.14	-.05
Frequency of contacts with social network members	6 9	5 7	13	- 27	.04	32***	18
Institutional Barriers							
Problems with agencies	8	14	.14	-.14	01	38**	- 15

Characteristics	Mean	S.D.	Disability Couns.	Job Couns.	Employ-ment	Transp.	State Cert.
Demographic Characteristics							
Age	55	19	-.26	-.39**	.03	.04	-.18
Years of education	9.2	3.5	-.12	-.02	-.07	.10	-.35
Lives in.							
Intact family	.23	.43	.10	.40**	-.17	-.06	-.17
Alone	.45	.50	-.10	-.20	-.29***	.08	.35***
With other than family	.05	.21	-.09	-.05	.69*	-.20	-.07
Family income	5456	3862	.39**	-.26	-.06	-.10	-.07
Income source is salary	.09	.29	.34**	.69*	-.10	-.29***	-.10
Need for Services							
Demoralization score	5.0	4.7	-.35***	-.19**	-.16	.31***	.00
Services reported needed							
Disability counseling	.32	.48	.58*				
Job counseling	.09	.29		.69*			
Employment	.14	.35			.80		
Transportation	.32	.48				.55*	
Certification	.23	.43					.58*
Mean			.13	.05	.09	.45	.09
S.D.			.35	.21	.29	.51	.29

Significance of T: * Less than .01; **.01-.05; ***.06-.10.

opposite of what was found for Hispanics.

Since social network integration is positively associated with use of transportation and employment programs, we were interested in determining whether these variables indirectly influenced use through their effects on perceived need. The partial correlations indicate that this is the case with respect to use of transportation services. With respect to other services, social network integration does not have an indirect effect through its interrelationship with perceived need.

To summarize the findings: among disabled blacks, social network members provide information and advice which leads to use of some services. This suggests that the alternative resources hypothesis is not applicable to the use of services among disabled blacks. In contrast, among disabled Hispanics, integration into the social network is related to not using services, indicating that friends and relatives perform services analogous to those that institutional help providers offer the disabled. Perceived need has more of a direct influence on use of services among Hispanics than it does among disabled blacks. Among disabled Hispanics, cultural barriers reduce access to use of employment programs. Among both groups, problems with agencies, our measure of institutional barriers, do not prevent the use of services by the disabled.

The Elderly

Literature on Utilization of Services for the Elderly

In contrast to the lack of knowledge about the use of most social services, there is more information available on the use of services by the elderly, especially health services. Some of the literature touches upon issues of concern to this study, but little is known about the applicability of findings to the Hispanic elderly. For example, the literature refers to such areas as the underutilization of certain kinds of services and — relevant to the alternative resources hypothesis—to the use of kinship networks as alternatives to health care. Nevertheless, with a few exceptions, the literature does not touch upon patterns of use among the Hispanic elderly.

A few studies have examined the use of services among white and minority elderly, finding lower utilization among minority elderly. For example, some studies of white and minority elderly indicate that the latter have less knowledge and consequently make less use of community-based health services,[8] even though research indicates a higher need for health services among minority elderly.[9] The same study also noted that among the Hispanic subgroup the Mexican Americans demonstrated greater knowledge of various services than Puerto Ricans. Lacayo et al. focused upon the needs for and use of social services by different Hispanic-origin elderly.[10] The study indicated that with assumed high need, Hispanic elderly are very low users of social

services. Puerto Ricans were shown to report the highest needs, to have the greatest knowledge — in contrast to the findings reported above with respect to use of health services — and to use services more than other Hispanic groups. Specifically, 84 percent of Mexican Americans and Cubans used fewer than three services — including such widespread services as food stamps — while 72 percent of Puerto Ricans and 86 percent of other Hispanics also used fewer than three services. The study suggests a strong causal relationship between need, knowledge, and use.

Some of the studies reviewed provide evidence that barrier and alternative resource theories are applicable to the utilization of services by minority elderly. One study examined the relationship between agency characteristics and the proportion of minority elderly served by community-based health services among the 10 percent of counties with the highest percentages of minorities.[11] The study found that 17 percent of agencies in black minority counties served a proportion of older blacks lower than their proportion in the county population. In counties with large Hispanic populations, 38 percent of agencies served a proportion of Hispanic elderly lower than their proportion in the county. Counties with large Asian or Native American populations also had low rates of service in comparison to the respective populations. The study found organizational characteristics, such as the percentage of minorities on staff, location in minority neighborhoods, conducting door to door and media outreach, and providing staff training on the needs of minority elderly, to be related to the proportion of minority elderly served by the agencies. However, at least one study made the argument that cultural differences among the elderly may influence the use of health services. Eribes and Bradley-Rawls[12] argue that, in the Southwest, Mexican-American use of nursing homes decreases as family income increases because nursing homes are culturally defined as the alternative of last resort.

The field of gerontology has paid much attention to the role of social networks among the elderly in supplementing or replacing institutional care.[13] The research supports the hypothesis that the more varied the elderly person's social network, and the greater the interaction with network members, the less likely the use of institutionally based services. For example, O'Brien[14] found that frail elderly relying on relatives and others for help with home chores, meals, and other forms of assistance were less likely to make use of home care services. Smyer[15] found a similar relationship with respect to problems of the mentally impaired elderly.

While these studies suggest the applicability of alternative resources theory to the utilization of services by the elderly, they focus on a substratum of the elderly with a pressing need for services. It is less clear how the alternative resources argument would apply to the majority of the elderly who are not frail or mentally impaired. In addition, the

social network studies have not examined minority or Hispanic elderly. We would expect that among Hispanic elderly use of services would be related to the social network in the same way as among the elderly of other groups studied above. In fact, given the low acculturation of the Hispanic elderly and the familial character of Hispanic life, we would expect an even stronger relation between social network integration and reliance on alternatives to professional services.

In sum, the studies reviewed suggest that there are cultural and institutional barriers to the use of services by the elderly. At the same time, they suggest that the elderly's social networks may provide alternatives to institutional care. These findings constitute our point of departure for examining the use of social services among the elderly in our study area. Our objective is to determine which explanation best fits the use of services by the elderly of each ethnic group in the area, and if both alternative resources and cultural barriers are applicable, to determine how each factor influences the use of services by the elderly. We first examine the patterns of use of services by the ethnic groups and then analyze the influence of factors in our model separately for each ethnic group.

Utilization Patterns

We asked about household members' needs for and the use of five services for the elderly: geriatric health services, visiting homemaker services, counseling about problems of the elderly, recreation programs, and financial assistance. Table 5.5 shows the proportions needing and using these services among Hispanics, blacks and whites. Overall, financial assistance, recreation and health services are the most needed, while few elderly report needing counseling and visiting homemakers. Relative to other groups we examined, the elderly who need services are most likely to receive them. This is especially the case with respect to services which the majority report needing. When we examine services needed by relatively few elderly — counseling and home care, and to a certain extent, recreation — a higher proportion report not receiving them.

Among the elderly, the likelihood of receiving needed services generally cuts across ethnic lines. For example, 97 percent of the elderly in each group who report needing financial assistance receive it. Hispanic and black elderly are less likely than whites to obtain counseling, and white elderly are less likely than the other elderly to receive needed recreation programs. Among Hispanics and whites, a substantial percentage report not receiving needed visiting homemaker services, but relatively few report needing these services. Hispanics and blacks are more likely than whites to report needs for health services, recreation, and financial assistance, but all three ethnic groups are equally unlikely to need visiting homemakers and counseling. Blacks report a greater need for recreation programs while Hispanics report a

greater need for financial assistance.

It may be recalled from the discussion of sampling in Chapter 2 that to augment the elderly sample, we interviewed some respondents at a senior citizen center. We considered the possibility that these clients may have had more access to services than those interviewed at home, thus inflating our estimates of utilization. We examined the needs for and use of services among the two groups of respondents and found differences with respect only to use of recreation programs. We believe that the proportions of minority elderly who need and use recreation programs are no greater than those shown for elderly whites in Table 5.5.

Table 5.5 summarizes the ethnic groups' needs for and the use of services, first excluding and then including financial assistance in the summaries. Half of the elderly report needing at least one non-financial service, while seven out of ten need services when we include financial assistance. Hispanic and black elderly are more likely than whites to need services. More than eight out of ten black and Hispanic elderly, but only four out of ten whites, report needing at least one service.

As a group, the elderly are more likely than other groups in the area to receive needed services. Overall, four out of five elderly persons report receiving all services needed. Moreover, inclusion of financial assistance in the summary data does not substantially improve the utilization pattern, as it does in the utilization pattern of female heads of family and other groups. For example, 21 percent of all households with an elderly person receive fewer non-financial services than needed, but the percentage is reduced to only 18 percent when we include financial assistance in the summary. This appears to contradict Lacayo et al.'s findings[16] which report low use of services by Hispanic elderly in relation to assumed high need. However, the methodologies in ours and the Lacayo study differ. They asked about the use of many services, while our study focuses upon a small number of services judged by providers in the area to be highly needed by elderly residents. We asked directly about need for services while the Lacayo study asked only about use.

Elderly whites are the least likely and blacks are the most likely to receive services. Thus, while the majority of whites report not needing services, those who do are the least likely to receive them. Black and Hispanic households with elderly members, on the other hand, are more likely to need services, but also more likely to receive them. In this respect, Hispanic households underutilize services for the elderly more than black households, but less than white households. We now examine the applicability of factors in our model to the use of services by the elderly Hispanics, blacks and whites.

Table 5.5

Need for and Use of Services by the Elderly, According to Ethnicity. In Percentages.

Services	Hispanic		Black		White		All Groups	
Geriatric Health Services								
Needed	33		35		13		28	
Received		29		35		10		26
Not received		4		0		3		2
Not needed	67		65		87		72	
Total (=100%)	(54)		(34)		(38)		(126)	
Counseling about Elderly's Problems								
Needed	17		9		3		10	
Received		9		3		0		5
Not received		8		6		3		5
Not needed	83		91		97		90	
Home Care								
Needed	14		6		10		11	
Received		7		6		5		6
Not received		7		0		5		5
Not needed	86		94		90		89	
Recreation Programs								
Needed	37		50		24		37	
Received		30		50		13		31
Not received		7		0		11		6
Not needed	63		50		76		63	

Services	Hispanic		Black		White		All Groups	
Financial Benefits								
Needed	80		62		26		59	
Received		78		59		26		57
Not received		2		3		0		2
Not needed	20		38		74		41	
Non-Financial Services Needed								
None	37		24		69		43	
One	43		56		21		39	
Two	6		15		5		8	
Three	14		5		5		10	
Total number (=100%)	(54)		(34)		(39)		(127)	
Received fewer services than needed	24		8		42		21	
Total number (=100%)	(34)		(26)		(12)		(72)	
All Services Needed (Including Financial)								
None	13		12		62		28	
One	19		24		15		19	
Two	44		38		8		32	
Three	24		26		15		21	
Total number (=100%)	(54)		(34)		(39)		(127)	
Received fewer services than needed	17		10		36		18	
Total number (=100%)	(47)		(30)		(15)		(92)	

Utilization by Hispanics

Table 5.6 examines the correlations between factors in the model and the use by elderly Hispanics of geriatric health services, home care, counseling for the elderly, and recreational programs. For geriatric health services, home care, and counseling, few variables in the model show strong and significant correlations. The index of help is significantly correlated with use of health services, but not with use of other services. Contrary to what would be expected, age is negatively correlated with use of health services and home care, and the acculturated are the least likely to use counseling services.

Perceived need shows the highest correlations with use of services. In comparison to the use of services for female heads of family, mental health services, and services for the disabled, the correlations between perceived need and use of services for the elderly are very high, reflecting our findings from Table 5.5 that the elderly were more likely than other groups to receive the services reported needed. We also included demoralization as a measure of need. It may be seen from the table that the number of demoralization symptoms reported is not related to the use of counseling services, as was the case with respect to counseling for the disabled, but is negatively related to the use of home care. This finding is also contrary to what would be expected, and we examine below whether other variables explain the relationship.

From the viewpoint of applicability of factors in the model, the most interesting correlations are those related to use of recreation programs. In line with the hypothesis that integration into the social network provides an alternative to the use of this service, those living alone are more likely than others to use recreation programs. We also find the only instance in our data supporting the institutional barriers hypothesis. The greater the number and frequency of problems perceived with service agencies, the less likely the use of recreation programs. With respect to use of other services, the correlations between perception of problems and utilization are either positive or not significant. The oldest and those who have lived longest in their neighborhoods are the most likely to use recreation programs; those with relatively higher household incomes are the least likely to use this service.

In our multiple regression analyses we examined the interrelationships among factors in the model and use by elderly Hispanics of geriatric health services, home care, and recreation programs. We did not analyze use of counseling services because only perception of need is significantly associated with use of this service. Perception of problems with agencies is also associated with use of this service, but the positive direction of the correlation is contrary to the institutional barriers hypothesis. Below we discuss the results and implications of the regressions examining use of each of these services.[17]

We first examined factors associated with the use of geriatric health services. Table 5.6 indicated that integration into the social network was positively related to the use of geriatric health services and that the oldest were the least likely to use this service. The oldest are the least likely to perceive a need for health services. This may be because — as Cantor and Mayer indicate in their analysis of use of health services by minority elderly[18]—the very old do not think medical care can much help the maladies of old age. However, the regression results indicate that age does not indirectly influence utilization through its effect on perceived need. Since there is a weak relationship between the help index and perceived need, help from social network members has no indirect influence on utilization through its effect on perceived need. Holding age and help from social network members constant, perceived need has the only significant influence on use of this service. Thus, other factors not accounted for in our model influence elderly Hispanics' perceptions of need for geriatric health services.

Although we found no significant correlation between acculturation and use of services, we considered the possibility that acculturation interrelated with the social network variables or with perceived need for health services. However, controlling for the relationship between acculturation and the other variables, acculturation has no effect on use of health services.

Turning now to the influence of factors in our model on use of home care services, the correlations in Table 5.6 suggest that neither the alternative resource nor the cultural barrier hypothesis is applicable to use of this service. Only age, perceived need, and demoralization —an additional measure of need — have significant correlations with use of home care. Both age and demoralization show unexpected negative relationships. Because the oldest are the most demoralized and less likely to perceive a need for home care, we considered whether age explains the influence of the need variables. However, holding age constant, demoralization and perception of need have the strongest effects on use of home care. It is unclear why the most demoralized are less likely to use home care. It may be that those with pressing emotional problems do not perceive home care as a solution to their problems. On the other hand, receiving home care may reduce psychological distress.

We turn to a discussion of those factors associated with use of recreation programs among elderly Hispanics. Table 5.6 shows interesting correlations between variables and use of recreation programs. Social network variables show no relationship with use of this service, but in line with the alternative resource hypothesis, living alone is positively related to use of this service. In line with the institutional barrier hypothesis, perception of problems with service agencies is negatively related to use of recreation programs. Family income is negatively related, while age and length of residence in the neighbor-

Table 5.6

Elderly Hispanics (N=54) Correlations Between Variables and Use of Geriatric Health Services, Home Care, Counseling, and Recreation Programs

Characteristics	Mean	S.D.	Geriatric Health	Home Care	Counseling	Rec. Program
Social Network Characteristics						
Index of help	2.4	1.4	19***	-.01	-.01	-.05
Total number of persons mentioned	4.2	2.5	15	11	03	-.12
Frequency of contacts with social network members	8.6	5.6	11	-.05	-.05	02
Membership in voluntary associations	1.5	2.4	06	04	04	.09
Cultural Barriers						
Acculturation index	.6	1.1	-.02	09	00	09
Institutional Barriers						
Problems with agencies	1.1	2.3	06	19***	44**	-.2?**

Characteristics	Mean	S.D.	Geriatric Health	Home Care	Counseling	Rec. Program
Demographic Characteristics						
Age	63 4	14 5	- 18***	- 12***	04	.23**
Lives·						
Intact family	18	39	11	05	01	- 20***
Female-headed family	11	32	03	- 10	09	- 23***
Alone	41	.50	- 13	05	.00	.54*
With others	30	46	02	- 02	- 07	- 24**
Family income	7613	8741	- 08	- 02	- 01	- 27**
Number of years in current residence	7 0	6 2	- 05	13	- 07	30**
Need for Services						
Demoralization score	5 7	7 5	- 09	- 38*	- 06	- 27
Services needed						
Geriatric health services	33	48	.91*			
Home care	15	.36		68*		
Counseling	.17	.38			71*	
Recreation Programs	.37	.49				.84*
Mean			30	.09	.30	.07
S.D.			46	29	46	.26

Significance of T; * less than .01; **.01-.05; ***.06-.10.

hood are positively related to use of this service. The latter relationship suggests that those with longest residence in the neighborhood might have the most acquaintance with agencies.

In our analysis we considered the possibility that background characteristics such as age or years of residence might mask the influence of social network integration on use of this service. For example, if the oldest are the most likely to use recreation but also the most likely to rely on help from members of the social network, holding age constant might reveal that help from social network members is negatively related to use of this service. Controlling for the relationship between social network integration and age or other background characteristics, the social network variables do not have significant effects. The regression analysis also indicated that among background characteristics only age has a significant effect on use of recreation programs. Therefore, in subsequent regressions we included only age.

We saw in Table 5.6 that perception of problems with agencies is negatively associated with use of recreation programs, the only instance in the data supporting the institutional barriers hypothesis. Age, other background characteristics, and social network integration are not related to perception of problems with agencies, and therefore do not explain the negative relationship between perception of problems and use of recreation programs. Those elderly Hispanics living alone are significantly less likely than those living with others to perceive problems with agencies. Holding the type of living arrangement constant, perceiving problems with agencies has less influence on use of recreation programs. Furthermore, in relation to perceived need, perception of problems with agencies has a minor influence on utilization. Whether or not elderly Hispanics perceive problems with agencies, those who feel they need recreation are the most likely to use such programs.

We noted the high positive correlation shown in Table 5.6 between living alone and use of recreation programs. Living alone influences use of this service even when taking into account its relationship with perceived need. It makes intuitive sense that recreation programs will be most attractive to those who live alone. However, those living alone may also be older, and this may influence the use of recreation programs. The regression analysis confirmed this. Whether or not the elderly live alone, the oldest are the most likely to use recreation programs. While those who live alone may use recreation because they are older, it could also be that they rely on others in their social network, and this may in turn influence their use of recreation programs. We examined the relation between living alone and integration into the social network, using as an indicator of the latter the index of help from social network members. We found that holding help from social network members constant, living alone has no effect on utilization.

Thus, in addition to the influence of age on living alone, those who live alone are the most likely to use this service when they do not have people in their social network who can provide companionship and other kinds of help.

To summarize the analysis results: among elderly Hispanics, social network members do not provide alternative resources to the use of services, nor do problems with agencies or low acculturation pose barriers to use of services. Age negatively and indirectly influences use of geriatric health services and directly and positively influences use of recreation programs. As with the use of other services, perceptions of need for services have the strongest influences on use of services among elderly Hispanics.

Utilization by Blacks and Whites

Table 5.7 examines the correlations between factors in the model and use of services by elderly blacks. It may be seen that for health services, home care, and recreation, there are perfect correlations between reported need and use. A small proportion reported using counseling services and, for these, only perceived need is significantly correlated with use. Among elderly blacks, indicators of integration into the social network show positive correlations with use of services, suggesting that the social network provides an information referral and advice function. An exception is use of counseling, which is negatively related to the size of the social network. In regression analysis, a perfect correlation assumes that a variable accounts for all the variation in the dependent variable. Since there are perfect correlations between perceived need and use of health services, home care, and recreation, the analysis below excludes perceived need.

In multiple regression analysis we examined the interrelationships among factors in the model and use of geriatric health care, home care, counseling, and recreation programs among elderly blacks. The correlations in Table 5.7 suggest that several background characteristics may explain the positive relationship between social network integration and use of geriatric health services. Those who live alone and those with higher incomes are less likely, while those reporting a higher number of demoralization symptoms are more likely to use this service. If these variables influence the extent of help received from the social network, they may explain the positive relation between social network integration and utilization. We found this not to be the case. Holding constant living alone and family income, social network integration still influences use of geriatric health services. The same results are obtained if we substitute other significant background characteristics that might explain the effect of social network integration, for example, number of years of residence in the neighborhood. However, demoralization indirectly influences use of geriatric

Table 5.7

Elderly Blacks (N=34): Correlations
Between Variables and Use of Geriatric Health
Services, Home Care, Counseling, and Recreation Programs

Characteristics	Mean	S.D.	Geriatric Health	Home Care	Counseling	Rec. Program
Social Network Characteristics						
Index of help	2.0	1 5	.33**	.00	00	13
Total number of persons mentioned	5 1	3.3	21	26**	- 25***	.31**
Frequency of contacts with social network members	6 5	5.4	13	.15	-.08	08
Membership in voluntary associations	1 9	1 9	- 03	- 18	- 08	41*
Institutional Barriers						
Problems with agencies	9	1.4	- 02	- 18	29***	34**
Demographic Characteristics						
Sex: female	.8	.4	- 23***	13	09	.07
Age	69 2	5 5	-.18	34**	- 07	-.04
Years of education	9.4	3.2	- 19	29***	- 20	-.30**
Lives.						
Alone	.68	.47	- 28***	17	12	19
With others	21	41	24***	- 13	- 09	-.21
Family income	6854	4820	- 26***	07	-.14	-.10
Number of years in current residence	14 4	14 3	- 42**	00	- 07	-.04
Need for Services						
Demoralization score	3.3	4.4	34**	- 01	-.09	- 06
Services needed:						
Geriatric health services	.35	.49	1.0			
Home care	.06	.24		1 0		
Counseling	09	29			.56*	
Recreation programs	.50	.31				1.0
Mean			35	.06	.03	50
S.D.			.49	24	17	.51

ance of T: *Less than .01, **.01-.05; ***.06-.10.

health services through its relation with help from social network members. The psychologically distressed are more likely than others to look for help from members of the social network, which leads to use of geriatric health care.

We now examine the use of home care among elderly blacks. Table 5.7 shows that the size of the social network, age, and education are positively associated with use of this service. We expected that living alone would also be associated with use of home care, but the correlation between the latter and use of this service is not significant. Living alone does not influence use of home care through its effect on the size of the social network, as was the case with respect to use of geriatric services. Although the small proportion of respondents using this service makes the regression results non-significant, the analysis suggests that age and education independently influence use of home care. The oldest and the most educated have the largest social networks, and this indirectly influences use of this service.

A small proportion of elderly blacks reported use of counseling. Table 5.7 showed that the size of the social network is inversely related to use of counseling among blacks. In contrast to the referral and advice function of social network integration with respect to use of other services, for counseling the social networks of elderly blacks appear to act as alternatives to professional help. We examined the influences of the size of the social network and perception of need. As with use of other services, we hypothesized that social network integration would indirectly influence use of counseling through its relationship with perception of need. The analysis shows that social network size negatively influences perception of need. But holding network size constant, perception of need has the strongest effect on use of this service. Thus, other factors not considered in our model influence perception of need. No other variable in our data significantly influences use of counseling. We expected that the number of demoralization symptoms reported would be positively associated with use of counseling, but this is not the case.

Turning now to the use of recreation programs by elderly blacks, Table 5.7 shows that the size of the social network is positively associated with use of this service. Membership in voluntary associations is also highly correlated with use of this service, in contrast to its lack of influence on use of other services. For some elderly, membership in associations may be intrinsically related with use of recreation programs. Churches sometimes sponsor senior citizen programs. Senior citizen programs may also form social clubs which can be considered voluntary associations, albeit within the sponsorship of a program. However, the relationship between these two variables could also have been due to the ways in which the questions were asked. We indicated above that those respondents interviewed in a senior citizen center were much more likely than the others to use recreation

programs. We examined the questions about use of recreation programs and membership in voluntary associations, and found that most of those interviewed in a senior citizen program also reported participating in a community center. Therefore, for elderly blacks and Hispanics we excluded responses to the community center item in constructing the index of membership in voluntary associations. After correcting this confounding effect, there still is a high correlation between membership in voluntary associations and use of recreation programs. Church membership is the main link between membership in voluntary associations and participation in recreation programs.

Although age and living alone were not significantly correlated with use of recreation programs by elderly blacks, their influence on use of other services suggested the possibility that they could indirectly influence use of recreation programs through their effects on the size of the social network or their relation to education. Therefore we examined the influences on use of recreation of the size of the social network and membership in voluntary associations, holding constant the possible indirect influences of the background characteristics mentioned above.

We found that age, living alone, and education have interesting indirect effects on utilization of recreation programs. Because living alone and the size of the social network are positively associated, holding age constant reduces the influence of social network size on utilization. The oldest have the largest social networks, but age is negatively related to use of recreation programs. Therefore, holding age constant increases the influence of social network size on utilization. Education has an interesting masking effect on the influence of the size of the social network. Educated people are less likely to use recreation programs, but they also have larger social networks. Thus education is directly and negatively related, but indirectly and positively related to use of recreation programs. Perhaps education creates interests that can be satisfied through means other than recreation programs. On the other hand, the more educated, the greater the size of the social network, which in turn leads to friendships conducive to joining recreation programs. If membership in voluntary associations is substituted for the size of the social network the regressions show the same effects: age and education indirectly influence use of recreation programs through their effects on membership in voluntary associations.

We expected that membership in voluntary associations and the size of the social network would mutually influence each other. People are likely to join associations through the friends they make, but joining associations also leads to making friends. The analysis showed that membership in voluntary associations has the most important influence on use of recreation programs, and that the size of the social network indirectly influences use of this service through its effect on

membership in voluntary associations. Education is related to not using recreation programs, but it indirectly influences such use through its positive effects on the size of the social network and on membership in associations. These relationships are not changed if we also consider the effects of age and living alone, variables which also have indirect effects on use of recreation programs through their interrelationships with the size of the social network and membership in voluntary associations.

To summarize the regression analyses· social network integration among elderly blacks serves to facilitate use of services. An exception to this is use of counseling, in which the social network provides an alternative to professional services. Background characteristics such as age, living alone, income, and education indirectly influence use of services among elderly blacks through their effects on social network integration. Notwithstanding these influences, perception of need is a strong factor in use of services among elderly blacks, with perfect correlations between need and use in three out of four services examined.

Table 5.8 shows the correlations between factors in the model and use of services among elderly whites. The table does not show correlations with use of counseling because no respondent reported using this service. In contrast to blacks, the negative correlations between the index of help and use of health services and home care suggest that integration into the social network provides an alternative to use of services. In line with this, those living alone are the most likely to use some services, as was the case with elderly Hispanics. Perception of need has the highest correlation with use of services but unlike among elderly Hispanics and blacks, demoralization is not associated with use of any service. As with the other ethnic groups, the correlations between use of services and problems with agencies do not support the institutional barriers hypothesis.

In multiple regression analyses we examined the interrelationships among factors in the model and use of health services, home care, and recreation programs among elderly whites. We saw in Table 5.8 that the length of time in the neighborhood and the index of help were negatively correlated with use of geriatric health services. Since among Hispanics and blacks, use of geriatric health services is associated with social network integration, it was puzzling why social network integration should be inversely related to use of this service among whites. Because among the elderly of the other ethnic groups, age and living alone indirectly influenced use of services, we considered whether age and living alone have this effect among whites. The results indicated that these background characteristics had no indirect influences on use of services. However, time in residence in the area indirectly influences use of geriatric health services. Because those living longest in the neighborhood are the most likely to receive help from friends and

Table 5.8

Elderly Whites (N=39): Correlations
Between Variables and Use of Geriatric Health
Services, Home Care, and Recreation Programs

Characteristics	Mean	S.D.	Geriatric Health	Home Care	Rec. Program
Social Network Characteristics					
Index of help	2 5	1 3	- 27***	- 28**	06
Total number of persons mentioned	4 8	2 9	- 13	01	- 18
Frequency of contacts with social network members	7.7	5 1	- 20	- 06	- 16
Membership in voluntary associations	2 4	3 0	- 04	05	-.07
Institutional Barriers					
Problems with agencies	1 1	1 8	13	17	- 13
Demographic Characteristics					
Age	71 9	16 3	12	11	.01
Lives alone	.36	49	10	07	36**
Number of years in current residence	26 1	18 4	37**	- 10	-.01
Services Needed					
Geriatric health services	12	34	88*		
Home care	10	.30		69*	
Recreation programs	23	43			70*
Mean			10	05	12
S.D.			30	.23	.33

Significance of T: *Less than 01; **.01-.05; ***.06-.10.

acquaintances, controlling for time in residence reduces the influence of help received from social network members.

Although Table 5.8 shows no direct relationship between age and use of health services, the relationship between age and use of services among elderly blacks and Hispanics suggested the possibility that the effects of age were masked by its interrelationships with other variables. Among elderly whites, the oldest have the least help from social network members. Since help is negatively related to use of geriatric health services, holding help from social network members constant increases the negative influence of age on use of this service. This is in line with Cantor and Mayer's finding[19] that the older the person, the less likely to view health services as useful to their life situation. Holding perception of need constant, the index of help and the amount of time living in the neighborhood have no direct effects on use of geriatric health services. The latter variables indirectly influence use of services through their effects on perception of need. Thus, age and perception of need have the strongest influences on use of this service.

We now turn to an examination of factors associated with the use of home care. Table 5.8 indicates that, as with use of geriatric health services, the index of help is negatively related, while perceiving a need for this service is positively related to use of this service. The social network variable indirectly influences use of this service through its relation to perceived need. However, regardless of the help received, perception of need is strongly associated with use of home care. Age and living alone, variables which indirectly influence use of services among the other ethnic groups, do not indirectly influence use of home care by elderly whites.

Table 5.8 showed that among elderly whites, indicators of social network integration are associated with not using recreation programs, but the correlations are not significant. As was the case with respect to use of this service by elderly Hispanics, and in line with the alternative resources hypothesis, those who live alone are more likely than others to use recreation programs. The relationship between living alone and social network integration has no effect on use of this service. Because elderly whites who live alone have smaller social networks than those living under other arrangements, the size of the social network does not significantly influence use of recreation programs. Living alone directly influences use of recreation programs and indirectly influences it through its effect on perception of need. Age, which indirectly influences use of other services, has no influence on use of recreation programs among elderly whites.

To summarize the results of our analyses: we find some evidence for the applicability of alternative resource theory to the use of services among elderly whites. In contrast, among elderly blacks social network integration serves to increase access to use of these services. For elderly Hispanics, we find no relationship between indices of social integration

and use of services. For the elderly, regardless of ethnicity, age and living alone indirectly influence use of services through their interrelationships with social network integration. Independent of the effects of these factors, among the elderly perception of need is highly associated with use of services, indicating that other factors not accounted for in our model influence perception of need.

Summary

Services for the disabled and the elderly aim to enhance the lives of these groups by helping them with living activities which others are able to manage on their own. By respondents' self-reports, one-fourth of Fordham-Tremont area households have a disabled person, with similar proportions in each ethnic group. If we exclude infirmities like arthritis and internal body dysfunctions, 10 to 15 percent of households in the area have a disabled person. Elderly residents, especially whites, comprise a substantial proportion of the Fordham-Tremont population.

Substantial numbers of disabled people in the sample—approximately half of whites and Hispanics, and six out of ten blacks — report receiving fewer services than needed. A smaller proportion of elderly persons — one out of four Hispanics, one out of ten blacks, and four out of ten whites — report receiving fewer services than needed. In comparison to the disabled, female heads of family, and those with emotional problems, the elderly are the most likely to utilize the services they report needing. The higher underutilization of services among elderly whites may reflect the high proportion of that group in the Fordham-Tremont area. This proportion is greater than found among elderly whites in the Bronx and New York City as a whole. This suggests that elderly whites in some inner-city areas may be at higher risk than their counterparts in more affluent areas, possibly because they are less visible than the elderly in majority white areas.

We tested the applicability of alternative resource theory to the use of services by the disabled and the elderly. We found that alternative resource theory is applicable to the use of services by disabled Hispanics, but not by blacks. Among blacks, integration into the social network is associated with use of services, indicating that members of the social network provide information referral and advice. The findings suggest that such advice influences perception of service needs by disabled and elderly blacks. The research literature reviewed suggested that social network members provide alternatives to use of health services among the frail elderly.[20] Examining use of services among elderly persons, most of whom can be assumed not to be frail or mentally impaired, we find that the alternative resources hypothesis is applicable to use of most of these services by whites, but not to the use of services by Hispanics and blacks. For elderly blacks, social network integration is associated with the use of services, and for elderly

Hispanics there is no relationship between social network integration and utilization.

Our data provide some support for the influence of cultural barriers in the underutilization of services. Acculturation is associated with the use of employment programs by the disabled. Acculturation is not a significant factor in the use of other services by the elderly or disabled. With respect to institutional barriers, we find no relationship between perceiving problems with agencies and using services among any of the ethnic groups.

Our findings in this and the previous chapters suggest several interventions which agencies may undertake to increase the use of services among the disabled, the elderly, female heads of family, and people with emotional problems. In the next chapter we summarize these findings and in the last chapter we discuss their programmatic implications.

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O'Brien and Wagner, note 14.
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6

SUMMARY OF FINDINGS

This study has examined the use of human services among Hispanic, black and white residents of a high-need area in the South Bronx. Because the preceding chapters present complex findings about use of many services among the three ethnic groups, this chapter summarizes the results of our analyses. The organizing focus is comparative, discussing differences with respect to use of types of services among the three ethnic groups. The first section summarizes the ethnic patterns of use of the mental health and social services surveyed in our data. The second section discusses two aspects of utilization inquired into but not integrated into our previous analysis — knowledge of and satisfaction with services. The chapter then concludes with a comparative summary of the factors associated with use of services. Here we assess the applicability of the two explanations of underutilization tested in the study: alternative resources theory, which hypothesizes that Hispanics underutilize services because they rely on informal help from members of their social networks; and the subcultural aspect of barrier theory, which hypothesizes that Hispanics do not use services because of culturally-induced predispositions against using bureaucratically organized services.

Patterns of Use of Services

Our findings underscore the high level of need for services in inner-city communities like the one we surveyed. Evidence of this is indicated by the key findings from Chapter 2 on respondents' eligibility for services. One-third of families in the sample are female-headed, a proportion close to census estimates for the Bronx. The proportion of minority elderly in the area — one in ten — is the same as found in the Bronx as whole, but the proportion of elderly whites — one out of five — is higher than found in the Bronx and other New York City boroughs. A substantial proportion of respondents — one-fourth — report a disabled person in the household. One-fifth of respondents report emotional problems; and in response to the Demoralization Scale we administered, slightly higher proportions report eight or more symptoms associated with mental illness. The data also show a

Table 6.1

Percent Receiving Fewer Services than Needed, According to Type of Service and Ethnicity

Services	Hispanic	Black	White	All Groups
Mental Health Services				
Reported emotional problems	16	15	15	15
Reported more than eight demoralization symptoms but did not use mental health services*	70	94	67	64
Services for Female Heads of Family	76	75	—	75
Services for the Disabled	49	64	55	53
Services for the Elderly	24	8	42	21
Specific Services with Relatively High Need and Relatively Low Use				
Mental health services	Private therapist Prevention program		Private therapist	
Services for female heads of family	Job training Adult education	Job training		
Services for the disabled	Transportation State certification	Transportation State certification Disability counseling	Transportation State certification Disability counseling	
Services for the elderly	Counseling			

*Did not report emotional problems; reported emotional problems but did not receive services, or reported not needing services.

considerable number of multiple-need households. For example, one-third of elderly blacks and Hispanics also report physical or mental disabilities and approximately half of Hispanic and white disabled persons also report emotional problems. Overall, nine out of ten households have at least one member potentially eligible for one of the four types of services we examined; and one-fourth of households are potentially eligible for two of these types of services.

Given the indicators of need reported above, the study found considerable underutilization of human services among all the groups we studied. It will be recalled that to determine utilization, we asked respondents with family members potentially eligible for each type of service to report the need for and use of specific services. Table 6.1 summarizes respondents' reports of needs and use of all services. It may be recalled that we define underutilization as receiving fewer services than reported needed. With respect to mental health services we also examined reported use of services among those reporting eight or more symptoms in the Demoralization Scale.

It may be seen that the elderly report the lowest percentage of underutilization, while the disabled, female heads of family, and people with emotional problems have higher proportions receiving fewer services than needed. If use of mental health services is limited to those reporting a need for such services, mental health services are the least underutilized. However, if underutilizers include those reporting a high number of symptoms but not reporting a need for such services, there is as much underutilization of mental health services as there is among the highest underutilizers — female heads of family.

Because the proportions shown in Table 6.1 summarize reports of need across services, it could be argued that this procedure inflates the number of services needed For example, those who reported needing one service may automatically report needs for other services not necessarily needed. To assess the adequacy of the underutilization estimates in Table 6.1, we examined the averages of correlations between perceived need and use of each service. Thus, with respect to mental health services we averaged the correlations between need and use of inpatient services, outpatient services, private therapists, and prevention programs. The correlation averages for types of services have the same rank order as the percentages shown in Table 6.1. Therefore, we conclude that the estimates of underutilization are not inflated by the way in which respondents answered the questions about needs for specific services. If these proportions of underutilizers are projected to the total population of the area, then many Hispanic, black and white residents in inner-city areas like the South Bronx are not receiving the services they need. Even among the elderly, the least underutilizing group, the small proportion receiving fewer services than needed represents large numbers of people in need of services.

Table 6.1 also lists specific services with reported low use in relation to high need. With respect to mental health services, the use of private therapists and prevention programs is reported as the most underutilized, while outpatient services and non-psychiatric physicians are more widely used. Among female heads of family, job training services and adult education are the least utilized, while family counseling and day care are more used in relation to reported need. Among the disabled, transportation and state certification of disability, which qualifies a disabled person for benefits and rehabilitation services, are the most underutilized, while disability and job counseling and employment programs are relatively less needed but more utilized. Among the elderly, counseling is the least utilized service in relation to reported need, while geriatric health care, home care, and recreation programs are more utilized.

In general, the table shows that the most needed services are the most utilized, that is, the higher the proportion needing a particular service, the higher the proportion receiving it. Low utilization tends to be confined to those services where only a minority report needing the service, for example, job training among female heads of family. However, some services are needed by a relatively high proportion of residents and at the same time are relatively underutilized. Among Hispanics, a substantial minority report needing preventive mental health programs, and among those who need this service, two-fifths do not receive it. Job training and adult education are needed by one-fifth of Hispanic female heads of family, and among these, less than one-fifth receive these services. For disabled Hispanics, one-half need state certification and of this proportion, two-fifths do not receive this service. Transportation is also needed by a substantial proportion of disabled Hispanics, and among these the majority do not receive this service. Among elderly Hispanics, counseling is the only service showing high underutilization in relation to need. Slightly less than one-fifth need this service, and half of these do not receive it.

Among blacks, services with high need and low utilization include job training for female heads of family, and counseling, transportation and state certification for the disabled. In relation to need, transportation is the most underutilized service among disabled blacks: one-third need this service and of these, two out of five do not receive it. Disability-related counseling and job training for female heads of family are also relatively underutilized in relation to high need: slightly less than one-third need and of these half do not receive these services. Fewer than one-fifth among disabled blacks need state certification, but among these half do not receive that service.

Among whites, the data identify the following as services with relatively high proportions reporting need and relatively few users: private therapists for those with emotional problems, and counseling, transportation, and state certification for the disabled. Disability

counseling is particularly underutilized among whites, given the high reported need and low use of this service.

In sum, although most of those needing a given service report using it, substantial proportions of Hispanic, black, and white residents in inner-city areas like the one surveyed are not able to utilize the mental health and social services which they report needing. In the next two sections, we summarize the results of our analysis indicating some of the barriers to use of these services.

Knowledge of and Satisfaction with Services

Our analysis of utilization has focused upon those factors associated with people's decisions to seek help. The discussion below supplements our findings on factors associated with help-seeking decisions by exploring two aspects of people's behavior related to use of services: awareness of available services and satisfaction with services.

Knowledge of what services are available is an important issue to consider in determining the extent of utilization of services. Beyond the question of alternative resource and barrier theory, a person's knowledge about what services are available will influence whether he or she seeks those services. We asked a subset of respondents about their knowledge of agencies in the area offering the specific services included in our survey. Because time constraints precluded asking the awareness question of all respondents, we have information only for approximately half (N=176). For each service, respondents were asked "Do you know where people can go for that service?". Responses were coded according to the specificity of the knowledge. The lowest value was assigned to responses indicating knowledge of a specific area agency providing that service. The more unrelated the agency was to the specific service, the higher the value assigned to the response, and the highest value was assigned to "do not know."

Table 6.2 shows differences among the ethnic groups in their knowledge of agencies offering services for the disabled, for the elderly, for female heads of family, and for mental health. The table also includes mean scores for each type of service and for all four types combined. Overall, people in the area know more about services for the elderly and the disabled than about services for female heads of family and mental health services. There is relatively little knowledge about services for female heads of family such as day care and family counseling. With respect to mental health there is relatively good knowledge about inpatient and outpatient services, but less knowledge about other types of mental health services.

Hispanics have the least knowledge of the three ethnic groups about what services are available. This is particularly the case with respect to services for the disabled and the elderly, where differences between Hispanics and the other groups are statistically significant. With respect

Table 6.2

Mean Knowledge of Services Scores,
According to Type of Service and Ethnicity

Services	Hispanic	Black	White	All Groups
Mental Health Services				
Inpatient facilities	4 55	4 66	3 37	4 24*
Outpatient facilities	5 26	5.54	4 07	4.98*
Private therapist	6.98	7.00	6 61	6 92*
Prevention programs	5.83	6 14	4.74	5.86*
Sub-score	6.36	6.63	6 18	6 38*
Services for Female Heads of Family				
Job training	6 20	6 13	6.24	6 20
Adult education	6.27	6.45	6 36	6.32
Family counseling	6 48	6.20	6.14	6.35
Day care	6 35	5.83	6.36	6.26
Sub-score	6.33	6.15	6.28	6.28

Services	Hispanic	Black	White	All Groups
Services for the Disabled				
Disability counseling	6.00	5.03	5.00	5.57*
Job training counseling	6 47	5 82	5.55	6.12*
Special employment	6.60	5.93	5.78	6 14*
Transportation	6.45	5 93	5 33	6.07*
State certification	6 02	6.03	5 20	5 81*
Sub-score	6 31	5.75	5 27	5 94*
Services for the Elderly				
Geriatric health services	6 20	5.12	4 17	5 48*
Counseling	6.22	5 14	4.76	5.66*
Recreation programs	6.10	4 71	3 47	5.17*
Home care	6 46	5.77	4.96	5.95*
Sub-score	6 19	5.30	4.43	5 57*
Overall knowledge score	6.30	5.96	5.54	6.04
Total Number	(100)	(29)	(47)	(176)

Note: Higher scores indicate less knowledge.

***Chi-square statistics significant at .10 or lower.**

to mental health services and services for female heads of family, differences among the ethnic groups are not significant. Table 6.2 shows a low level of knowledge about services among area residents. Considering that the highest value for the scale is 7 ("do not know" to all questions), a mean of 6 indicates little specific knowledge about where to seek services. In relation to the other groups, Hispanics have particularly low levels of knowledge about those services most known about in the area — services for the elderly and the disabled.

Our model of utilization assesses how integration into the social network and cultural barriers affect people's dispositions to seek help from service agencies In the analysis we used the questions about problems with agencies to measure institutional barriers. Contrary to our assumptions, the number of problems with agencies positively correlated with use of some services and had no relation to use of other services. We surmised that respondents' perceptions of problems with agencies signalled the extent of satisfaction with the services received rather than barriers to seeking services. However, this information is interesting in itself. Below we examine differences in satisfaction with services among the ethnic groups in the area.

Table 6.3 shows the percentages of Hispanics, blacks and whites dissatisfied with services. The percentages show those reporting problems "sometimes," "often," or "all the time." Responses are divided into three types of problems: the personal treatment received, the language barrier, and problems in applying for or receiving services. The table also shows summary measures of dissatisfaction — explained below — with the three types of agency problems. The majority of residents in need of services do not consistently experience problems with services. At most, one-fourth of the sample indicate having a particular problem. However, there is considerable variation among ethnic groups in the types of problems experienced. Problems with agency personnel — for example, lack of respect by workers — are the most frequently reported by all groups. As would be expected, the language barrier is a significant problem for Hispanics. One-fifth of Hispanic residents report that agency workers could not speak Spanish, and over one-tenth report having to use children as interpreters when dealing with agencies. Problems in applying for and receiving services are the least reported, but one-fifth report problems with some instances of this type of problem, for example, confusion on the part of the agency about the services the person is entitled to, having to spend a whole day at the agency before being attended, long waiting lists, and being subjected to many interviews before receiving the service.

It is notable that a greater proportion of white residents than of minorities report problems with agencies. This is particularl evident with respect to treatment by agency workers. For example, more than one-third of whites report that agency workers are hostile, while one-fifth of Hispanics and blacks report the same problem. With respect to

applying for and receiving services, equal proportions in each ethnic group report problems.

Table 6.3 also shows the mean dissatisfaction score of each ethnic group in problems with agency personnel, language barriers, and problems with services. These scores were computed by treating the frequency reported for each problem as a value and dividing the sum scores by the number of problems. For each of the three types of problems, scores range from zero for no problems to four for the most dissatisfaction. Whites are significantly more dissatisfied than blacks or Hispanics with respect to problems with agency personnel. However, because of the language barrier, Hispanics have significantly higher overall dissatisfaction scores than the other groups.

Among people eligible for different types of service, there is some variation in the extent to which problems are experienced. In data not shown, we examined the mean dissatisfaction among those in the three ethnic groups eligible for each type of service. Comparing differences among those potentially eligible for different types of services, greater proportions of the disabled and of people with emotional problems report problems than those in other service-eligible groups. The elderly are the least likely to report problems. Among the disabled, Hispanics are the most likely to report problems and blacks the least likely. Among the elderly, blacks and whites are more likely than Hispanics to report problems. Among female heads of family, Hispanics are more likely to report problems than blacks. Among those with emotional problems, blacks are the most likely and Hispanics the least likely to report problems. However, most of these interethnic differences are not statistically significant.

This section's findings show a considerable lack of knowledge about available services among residents of the area surveyed. Hispanics have the least knowledge of the three ethnic groups. One-third of area residents — a substantial proportion — report one or another problem with services received in agencies. Problems with the treatment received from agency personnel are the most prevalent among all ethnic groups, but for Hispanics an equally important problem is the language barrier.

Factors Associated with Use of Services

Chapters 3 to 5 examined the applicability of two explanations of underutilization of services — alternative resources and cultural barriers — to the use by Hispanics, blacks, and whites of selected social and mental health services. The analysis also examined the influences of background characteristics and, with respect to use of services for female heads of family, the influences of prior work experience and family formation. This section summarizes the results of our analyses to derive some conclusions about the influences of these factors on utilization.

Table 6.3

Types of Problems with Agencies:
Dissatisfaction Scores According to Ethnicity

Types of Problems	Percentage Reporting Problems*			
	Hispanic	Black	White	All Groups
Problems with Agency Personnel				
Lack of respect by agency workers	24	20	38	26**
Workers were hostile	22	22	35	25**
Inattention by workers	27	21	35	27
Workers did not seem to care about what they were doing	18	20	43	23
Mean dissatisfaction score	67	55	1 02	.72
Language Barrier				
Workers could not speak Spanish/English	23	10	4	16**
You had to use children as interpreters	13	1	7	9
Mean dissatisfaction score	.56	15	14	38
Problems with Services				
Lack of transportation to service	13	11	15	13
You were not eligible for service	14	11	12	13
You had no information about how to apply	15	12	12	14

Types of Problems	Percentage Reporting Problems*			
	Hispanic	Black	White	All Groups
Confusion on the part of workers about the services you were entitled to	18	26	28	22
Workers insisted in giving some service other than what you wanted	8	9	7	8
Workers sent you to different places by mistake	15	22	42	20**
You had nobody to take care of the kids and the agency would not allow you to bring them with you	11	5	6	7
You had to spend a whole day at the agency before being attended	16	23	40	23
You were not given complete information about the papers you had to bring	15	16	8	13
The program ended before the service you were receiving was completed	10	5	4	8
Waiting list one month or longer	19	14	21	20
You had to have more than three interviews before getting service	18	17	33	21**
Mean dissatisfaction score	.47	.40	48	45
Overall dissatisfaction score	1.65	1.08	1.61	1.51**
Total Number	(216)	(85)	(76)	(377)

*Experienced problem "sometimes," "often," or "all the time."
**Chi-square statistic significant at .10 or lower.

We tested the applicability of alternative resources theory by examining the influences of measures of integration into the social network. According to alternative resource theory, social network integration should be associated with not using services. Taking into account the interrelationships between social network integration and other factors, in our sample members of the social network provide alternatives only to use of mental health services among those with a low number of psychological distress symptoms, and to use of services for the disabled, namely job counseling, employment programs, transportation, and state certification. However, with respect to use of most services, social network integration is associated with using, rather than not using services.

An important finding of our analyses is that members of the social network, rather than providing alternatives to professional care, can facilitate the use of services by providing referral information and advice. Controlling for the influences of other factors on social network integration, members of the social network provide such functions with respect to use of mental health services among Hispanics, job training and day care among black female heads of family, geriatric health services and recreation programs among elderly blacks, special employment programs and transportation among disabled blacks, and psychological counseling among disabled Hispanics.

We tested the applicability of the cultural barriers hypothesis by examining the influences of acculturation on use of services among Hispanics. According to barrier theory, acculturation should be associated with use of services. With respect to use of mental health services, the analysis also examined how respondents' beliefs about the seriousness of problem behaviors described in vignettes influenced their use of services. There is no relationship between specific beliefs about the seriousness of these behaviors and use of mental health services. However, the cultural barriers hypothesis is supported by evidence that acculturation is related to the use of mental health services, job training among female heads of family, and special employment programs among the disabled.

We tested the applicability of the institutional barriers hypothesis by examining the influence of reported problems with service agencies on use of services. According to barrier theory, such problems should lead to not using services. However, in all but one instance negative experiences with agencies either correlated positively with or were not related to use of services. The findings lead to the conclusion that such perceptions more validly measure satisfaction with services than barriers to use of services.

Our analysis stresses need for services as an important factor in utilization. The need measures used in our study are subjective in the sense that they are respondents' reports of needs for services. However, in the case of mental health services, the analysis also included an

objective measure of need — the number of symptoms reported by the respondent in response to the Demoralization Scale. The logic of our analysis was to examine the influences of the factors in our model controlling for need. It was expected that the factors would have direct influences on utilization and indirect influences through their effects on need. For example, it was hypothesized that those integrated into a social network would be less likely to perceive a need for services and thus, not use them. However, in many instances need was the strongest predictor of utilization. This indicates that the factors in our model account only for part of the variation in use of services, and that other factors not accounted for in our model influence perceived need.

Although the direct influence of perceived need on use of services was stronger than expected, the analysis shows that the factors in our model influence perceived need, in some cases quite strongly. For example, members of the social network, in providing alternatives to professional help or advice and referral information, influence people's perceived needs, and thus indirectly influence the use of job training services among black female heads of family, and job counseling and employment programs among disabled blacks and Hispanics. Acculturation considerably influences perceived need for job training among Hispanic female heads of family, need for mental health services among psychologically distressed Hispanics, and need for special employment programs among disabled Hispanics. Previous participation in the labor force influences perceived need for job training among black and Hispanic female heads of family.

The findings show instances of services where ethnic groups differ in the ways that social network integration influences utilization. Among disabled Hispanics, social network integration is associated with using employment programs and transportation but among blacks, the social network facilitates use of these services. We also find instances where social network integration influences use of services among one ethnic group, but has no influence on the other ethnic group. For example, the social network provides alternatives to disabled Hispanics' use of state certification, but disabled blacks' social networks provide no function with respect to use of this service. Blacks' social networks provide information referral and advice with respect to use of day care among female heads of family, geriatric health services and home care for the elderly, and special employment programs for the disabled. With respect to these services, Hispanics' social networks provide no function.

These intricate interrelationships between types of service, type of social network function, and ethnicity make it difficult to generalize about the functions of social networks in utilization, but some conclusions may be abstracted from the analysis findings. The information and referral function of social networks is more prevalent among blacks than among Hispanics, and more applicable to occu-

pationally-related than to counseling-related services. The alternative resources function is more applicable to the situation of Hispanics and whites and to services for the disabled and the elderly than for other services. For service providers interested in how social networks need to be taken into account to promote utilization of a given human service, the most applicable conclusion of our data is that social networks have multiple influences on how potential users perceive and actually make use of services.

In sum, our analysis findings emphasize the importance of two factors in the utilization of services by Hispanics: integration into the social network and acculturation. In most cases social network integration provides advice and referral information conducive to use of services by Hispanics, blacks, and whites; and in some cases the social network provides an alternative to use of services for Hispanics. The findings also underscore the strong influence of acculturation in facilitating use of many types of services by Hispanics. Thus, the findings support the hypothesis that cultural barriers impede the use of services by unacculturated Hispanics. In Chapter 7 we review these and other findings to suggest recommendations to increase the use of human services by Hispanics and other inner-city residents.

7

CONCLUSIONS AND RECOMMENDATIONS

This study has examined the use of human services in an area of the South Bronx to establish the extent to which these services are underutilized, and to determine those factors associated with underutilization. The data indicate that the extent of underutilization varies by the service in question, but in all cases there are substantial numbers of people in need of services who do not receive them. The findings stress the roles of social networks and acculturation in influencing people's decisions about seeking help from service agencies. The recommendations we discuss here are based on our findings about the influences of these factors, and are aimed at increasing the utilization of human services by residents of inner-city areas. Since the data also show findings relevant to the experiences of those who actually receive services, we include recommendations about ways to enhance human services for residents of inner-city areas. Finally, our findings suggest some vital next steps in research on needs for and utilization of human services by Hispanics and other residents of inner-city areas.

Recommendation 1. Human service agencies should incorporate well-thought-out and continuous outreach efforts into their delivery of services. Government agencies responsible for the provision of human services should encourage outreach by including or increasing allocations for outreach efforts as part of their reimbursement mechanisms for service contracts.

We believe that the most effective way to increase the utilization of human services lies in the direction of innovations in outreach. To develop this argument, it is useful to review the implications for program interventions of institutional and cultural barriers theory and of alternative resources theory.

Barrier theory asserts that institutional characteristics of service agencies keep potential clients from using the services offered by these agencies. To attract users, therefore, agencies would have to modify their structures, for example, increase the number of bilingual professional staff and make services less impersonal and bureaucratic. Our data do not provide any evidence that people's negative perceptions of how services are rendered keep them from using services. For example,

we find no negative correlations between experiencing language barriers and use of services. Therefore, our findings appear to run contrary to those of several attempts by community agencies to increase Hispanic utilization by modifying their service structure. For example, Scott and Delgado[1] showed that after increasing bilingual staff and coordinating the services offered with the needs of the Hispanic community, a mental health agency in Worcester, Massachusetts, was able to attract greater numbers of Hispanic clients to the program. Two interventions in the Southwest[2] showed similar results. Implicit in these interventions is the notion that positive attitudes toward the agency by potential clients are acquired through a process of diffusion, whereby clients who are satisfied with services tell others who will in turn be disposed to come to the agency when they need services. However, the program interventions suggested by these studies may not be in opposition to those suggested by our data. An examination of the accounts of the interventions discussed above suggests that they also utilized outreach, a more direct way of linking those in need with services. Our findings with respect to the lack of a relationship between perceptions of problems with agencies and utilization lead us to posit that a necessary ingredient in attempts to modify agency structures to render them more acceptable to potential clients is the type of outreach efforts which accompany agencies' modifications of services. We venture to assert that without outreach — efforts to find those in need of services and to persuade them to make use of available services — modifications of agency structure will have less of an impact on utilization.

Evidence of the importance of outreach efforts in increasing utilization is supplied by our research experience with Fordham-Tremont Community Mental Health Center's (CMHC) Project COPA (Community Organization for Patient Access). Project COPA was one of five minority mental health demonstration programs funded by New York State's Office of Mental Health to develop innovative ways of increasing the utilization of and enhancing mental health services for minorities. Focusing upon chronically mentally ill residents of the South Bronx, one of Project COPA's objectives was to increase the representation of Hispanic clients in Fordham-Tremont's aftercare clinic. Making use of preliminary findings from our research,[3] the project conducted intensive outreach among patients about to be discharged from inpatient facilities and among their families. This strategy was instrumental in increasing the proportion of Hispanic clients in the aftercare clinic by 10 percent.[4] In tune with the interventions described by Scott and Delgado and others, Project COPA also modified the structure of services by using a bilingual professional staff and by offering services in a manner more congenial to Hispanic populations. These efforts also brought about positive outcomes in terms of improved client attendance and psychosocial adjustment. The important point which we

believe Project COPA shows is that modifications of agency structures must be in tandem with efforts to reach and attract clients to services. Our research findings suggest some of the components which these outreach efforts should incorporate, discussed under the following recommendations.

Recommendation 2. In devising outreach strategies for Hispanics and other inner-city residents, agencies should address ways of enlisting potential clients' social networks and take into account differences in acculturation, the extent of knowledge among the area population about available social services, and potential clients' perceived needs for the services offered.

One of the most suggestive findings in our research is the relationship between integration into the social network and the use of services. Our research finds linkages between the social network and utilization to be more complex than conceptualized in previous explanations of underutilization. In some instances the social network helps people to get services by providing referral information and advice; in fewer instances, members of the social network provide alternatives to the use of professional services. Under either relationship, the data suggest that social networks are instrumental in people's decisions to seek services, and that service agencies need to be cognizant of social networks' possible functions when they set out to find potential clients or when they decide on a treatment strategy for a client who comes to seek services. In practical terms, the data suggest that service providers need to establish face-to-face contacts with relatives, friends, and associates of potential clients when they undertake outreach in the community, and that intake personnel need to learn about members of the applicant's social network that may have been involved in the decision to seek help, so that these may be enlisted to help clients with the course of treatment prescribed by the agency. Since members of the social network advise each other, knowledge of the social network can also be useful to the program in better understanding the client's problems and in convincing her or him to enroll in the program and to follow a prescribed course of action.

Outreach is particularly important among those clients who do not have a large or active social network, where few relatives and acquaintances are reported and where those in the network do not see each other often. This may signal to the program the need to make extra efforts to secure services for the client or the need to work among social network members to promote their advice function.

Fordham-Tremont CMHC's experiences in Hispanic Access, the demonstration project which this research was a part of, illustrate how social network members may be enlisted to link potential clients with services. Clients who came to the program for help were asked extensive questions about relatives, friends, and neighbors who could be called in to help with specific problems the client might have, and

the program tried to enlist them in solving the client's problems. For example, when clients were apprehensive about visiting some agency to secure a service, neighbors were asked to accompany the clients to the agency.

Fordham-Tremont CMHC's experiences with Project COPA, described above, illustrate the way in which social network may be taken into account in outreach efforts aimed at finding potential clients. When a relative of a patient could be contacted, outreach was instrumental in convincing the family that aftercare would help both the patient and his/her family. These initial contacts were followed up with an invitation to the family to bring the patient to the aftercare clinic. We found that in over 90 percent of the cases initial contacts followed by a visit to the clinic resulted in enrollment in aftercare treatment. The research concluded that the critical component in successful outreach was the outreach worker's contacts with relatives of the patients. Thus, our data suggest that programs serving Hispanics and other minorities need to consider how clients' social networks influence their decisions to seek services and how members of the social network may be enlisted to provide more effective services to clients.

The person's level of acculturation is another factor which needs to be systematically considered when conducting outreach efforts. Our findings show several instances of services where the unacculturated are less likely to use services. In some cases, this can be traced to the unacculturated's being less likely to perceive a need for services. This suggests that outreach efforts need to tailor their approaches to the acculturation level of potential clients. One way of doing this is for outreach efforts to educate unacculturated persons, giving them basic information about how the service is rendered and what needs it addresses. An example of this is Acosta et al.'s "Tell It Like It Is" intervention,[5] in which Hispanic clients about to undergo psychotherapy are given a brief videotaped presentation about the objectives and expectations of therapy. A second and complementary way of taking acculturation level into account is for outreach workers to adopt interpersonal approaches in tune with the beliefs and interaction norms of unacculturated Hispanics. An example of this is Inclan's proposal that therapists adopt an interpersonal style based on traditional Hispanic notions of deference with first-generation clients, and an interpersonal style based on the professional role model with second-generation clients.[6] Differences in the interpersonal style adopted are also applicable to members of the potential client's social network who may differ in the level of acculturation. For example, when the potential client is an adolescent, different approaches are prescribed for the client and for his or her first-generation parents.

Outreach efforts also need to consider how to discern and address potential clients' perceived needs for service. Our findings indicate that perceived need has the strongest relationship to use of services.

However, people may not always be aware of their needs for help. Our data show this clearly with respect to use of mental health services. Many respondents with a high number of mental illness symptoms reported that they did not need mental health services. With respect to perceived need for other types of services, information and referral specialists often find that clients need to be helped in defining what kinds of services they need (see discussion below of Recommendation 8). This suggests that outreach workers need to incorporate into their repertory techniques for helping potential clients to define their needs for services, just as in intake interviews service providers help clients to clarify their problems and determine what services they need. On the other hand, it would be counterproductive to assume that every person contacted in outreach is a potential client. After exploring the problems and discussing how the service may help, the person may still decide not to seek help, and the outreach worker must respect that decision.

Recommendation 3. Government and non-profit agencies should cooperate in the development of centralized information and referral services for inner-city residents.

Our findings underscore inner-city residents' lack of knowledge about the availability and location of human services. To increase such knowledge, many communities have instituted telephone-based information and referral (I & R) services, where people in need of help may call one number to receive information about local agencies in their communities offering the indicated services. Such services go beyond communicating an agency name and telephone number. I & R specialists often must be sensitive to the implicit needs of clients. A client may need help with a problem not immediately apparent from his or her inquiry. A client may ask for help with a specific problem which, upon exploration by the specialist, turns out to be a number of problems. Thus, I & R services need to be staffed by professionals with a grasp of available services and the ability to discern what kinds of problems the client has. United Way has instituted I & R services in several areas with success in increasing the availability of services to clients.[7] These services are also useful in identifying needs not immediately apparent to policy makers.

In a city as varied as New York, and in inner-city areas like the South Bronx, I & R services would require a scope and complexity beyond those of current efforts. These services would be complicated by the multivaried ethnicity of New York. For I & R to work for Hispanics, for example, more than Spanish-speaking operators would be needed. Specialists would also need to have knowledge of Hispanic culture, and of the ways in which social networks may aid in seeking services. Complex as such an effort might be, our findings clearly suggest that inner-city residents would be helped by centralized I & R services. One approach might be to create a pilot I & R project in the South Bronx to determine whether the service helps to increase the availability of

needed services.

Recommendation 4. To increase utilization, outreach based on referral mechanisms between service providers in different agencies should be supplemented whenever relevant with interagency cooperative efforts to provide coordinated services in one setting.

Very often, clients are linked with services when a service provider in one agency refers a client to another service within the agency or outside. Many outreach efforts are predicated on cooperative referral mechanisms between agencies, whereby outreach workers from one agency cultivate relations with service providers in other agencies. While this is useful in linking potential clients with services, successful referrals depend on the motivation of the service providers to make them, on their ability to discern the need for other services, and on the potential client's recognition of the need for such services. For some types of services, interdisciplinary service teams may be more appropriate than interagency referrals. For example, the tendency of Hispanics with mental health problems to manifest such problems with somatic complaints has often been referred to in the literature.[8] Rather than establishing referral mechanisms between physicians and mental health specialists, such cases may be more adequately handled by interdisciplinary teams in a health care setting. To be effective, such teams would need to be sensitive to the intermixing of physical with mental health symptoms among Hispanics, and be alert to the possible mental health ramifications of many cases of physical complaints. Interdisciplinary service teams are not unknown in areas like the South Bronx, but more are needed. For example, because our data find so much overlap between reporting emotional problems and belonging to female-headed households, or being elderly or disabled, the need is apparent to create interagency cooperation between mental health services and services for the elderly, for the disabled, and for female heads of family.

Recommendation 5. Human service agencies serving inner-city residents should consider how they need to modify their organizations to improve the personal treatment of clients by personnel, improve the ways in which services are rendered, and overcome language barriers.

For most problems surveyed, one-fifth to one-fourth of respondents reported negative experiences with agencies. Among some subgroups — whites with respect to treatment received from agency personnel, Hispanics with respect to the language barrier — there are higher proportions reporting problems with agencies. While it should be gratifying to agencies in the area that the majority of clients do not report problems with the agencies they use, the proportion reporting problems represents a substantial number of clients dissatisfied with one or another aspect of services. As part of their policy, human service agencies serving inner-city residents should consider how they may improve the ways in which they provide services. In considering how

they offer services, agencies need to develop their awareness of the different cultural perspectives that inform minority clients' views of services.[9] For Hispanic clients, a minimum requirement would be the provision of adequate Spanish-speaking professionals. A useful starting point might be to institute periodic client satisfaction surveys. Besides the client satisfaction measures reported here, evaluation materials published by the National Institute of Mental Health and other agencies provide guidelines to evaluating clients' satisfaction with services.[10]

Recommendation 6. Government and non-profit agencies should fund policy-oriented research on the needs for human services among Hispanics and other inner-city residents. Of special importance are a mental health epidemiological study of New York's diverse Hispanic community and comprehensive needs assessment studies of human services for inner-city residents.

Our research is a modest effort to determine the patterns of utilization of services in a single catchment area of the South Bronx. The study establishes some benchmarks for the extent of need and utilization of a limited number of human services mainly among Puerto Ricans, a group representing approximately half of New York's Hispanic population, and other ethnic groups in the area. Because mental illness and use of mental health facilities are statistically rare, our sample provides only a glimpse of the extent of mental health problems among Hispanics. With respect to other service needs, our research provides even less information. We find, for example, that there are many inner-city residents reporting one or another type of physical or mental disability. While census data provide some estimates of the number of elderly persons and female heads of family in areas like the South Bronx, we do not have any information whatsoever about the extent of physical and mental disabilities among the population. Thus, the paucity of basic information makes it imperative that basic research be conducted on the extent of needs for human services among Hispanics and other inner-city residents.

There is a critical need to conduct basic epidemiological and needs assessment studies of Hispanic populations in New York City and other large metropolitan areas. A major step in that direction is the Hispanic HANES study,[11] which will produce reliable information on the health of the Cuban, Mexican American, and Puerto Rican populations. A useful next step would be to conduct large-sample epidemiological studies of mental illness, modeled on the Los Angeles catchment area study,[12] among the New York metropolitan area's Hispanic groups. These studies would provide federal, state, and local mental health agencies with the capacity to plan services for Hispanics based on needs priorities. For example, combined with admission-rates information already on hand, the epidemiological data would allow planners to estimate the extent of underutilization of different types of mental

health services.

Studies of the needs for human services among Hispanics would also help planners in government social welfare agencies to establish priorities for services. Information about the extent of physical and mental disabilities among Hispanics is especially needed. Census data on the disabled are not available, nor is it practical to gather them through the census. Information on the numbers of disabled people receiving services is fragmented among different government agencies, and estimates of the extent of different disabilities among the Hispanic population are not available. In this area as well there is a need to conduct large-sample epidemiological research on the extent of disabilities among the Hispanic population, and to compile information from different government agencies on the numbers of Hispanics receiving services for the disabled

Our research has focused upon the utilization of a small but representative set of human services. There is also a need for comprehensive research on inner-city residents' needs for and use of the many human services offered by government and non-profit agencies. Because most human services are applicable only to small subgroups of the population, large-sample research is necessary to determine the full extent of utilization of different services. The costs of such research would be more than compensated by its utility to planners in designing more effective delivery of services. Because our research focused upon users of services rather than the service delivery system, we cannot establish the availability of services in our study area. People may be inclined not to use services which are widely available or not available at all, and they may need services which are also widely available or not available. Thus, research on people's utilization of services must be complemented with research on the availability of services. Such research would entail surveying the full range of human service agencies in a given area and collecting information on client enrollment rates according to subgroups, client-to-staff ratios, and other service-related variables.

We believe that our investigation contributes to the research literature on Hispanic utilization of mental health services. Our study focuses on inner-city Hispanics, the majority of whom are Puerto Ricans, a Hispanic subgroup which has received relatively little attention in utilization research. The study broadens the scope of previous utilization research by inquiring into the uses of other services besides health and mental health services. By including need as a control factor, the study introduces a critical component often missing from previous utilization studies. Finally, our research has also helped to focus more sharply on some of the assumptions underlying alternative resources and barrier theories. It suggests that alternative resources and barrier theories pay more attention to the mechanisms by which these factors are supposed to operate — in the case of

institutional barriers, the means by which knowledge of and attitudes about mental health services are diffused to Hispanic non-utilizers; and in the case of alternative resources, the types of emotional supports and advice which render seeking professional therapy unnecessary.

This study began with the assumption that many Hispanics and other inner-city residents do not receive the human services they need. Our findings provide a useful corrective to that assumption by showing that not all services are equally underutilized. We nevertheless find that all services are underutilized to some degree by Hispanics and non-Hispanics. Our findings thus point to the need by government and non-profit human service agencies to consider whether they are reaching those in need in the inner-city. We hope that, in the current political climate, our research helps to make more salient the needs of inner-city residents and to underscore the responsibility of the polity towards them.

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APPENDIX

Reliability of the Demoralization Scale

To assess the reliability of the Demoralization Scale, we considered three sources of response bias: respondent error; acquiescence, which we explain below; and cultural differences in the way the questions were answered. Reliability of a scale can be affected by carelessness on the part of the respondent in answering questions and carelessness on the part of the interviewer in recording responses. For example, respondents may answer positively and negatively worded versions of the same item in the same direction. We assessed this source of error and found reliability coefficients higher than .9. Therefore, the scale is reliable with respect to respondent error.

Another source of bias in scales may be due to a respondent's tendency to give what he or she considers the answers expected by the interviewer. One way of assessing this type of bias is to examine acquiescence in responses, that is, the tendency to yea-say or nay-say when answering questions. Acquiescence may be measured by comparing the average of correlations among those scale items physically next to each other with the average of correlations among items reflecting the same scale dimensions. Roberts[1] indicates that acquiescence exists when the average of correlations between contiguous items is higher than the average of correlations between items reflective of the same dimensions. Because the scale was administered with same-dimension clusters contiguous to each other, we were not able to compute the acquiescence correlation measure used by Roberts. Instead, we compared the average of correlations of items within clusters with the average of correlations of the last item in one cluster with the contiguous item in the next cluster. The average of intracluster correlations was .03 higher than the average of contiguous item correlations. Greater discrepancy between the two correlation averages was found among whites than among the minority groups. Although our results are not strictly comparable with Roberts', in our data the average of contiguous item correlations is not substantially larger than the average of intracluster correlations. Therefore, we draw the conclusion that acquiescence is not a major problem in the Demoralization Scale.

We also considered the possibility that cultural differences influenced how members of each ethnic group responded to the Demoralization Scale. In their analyses of ethnic differences in psychological distress, Dohrenwend et al. [2] suggest the possibility that differences in response scores among ethnic groups might be due to cultural differences in how symptoms are expressed. To test this, they administered Edwards' social desirability scale[3] to several multi-ethnic samples of residents of a New York City neighborhood, using as contents for the scale the 22

items of the Langner scale.[4] Respondents were given cards, each of which listed a symptom, and were asked to sort these into nine groups ranging from very undesirable to very desirable. Puerto Ricans were found to rate most items more desirable than blacks or whites, suggesting that norms in Puerto Rican culture permit the freer expression of psychological distress symptoms, or that Puerto Ricans develop a greater number of symptoms to express a given degree of underlying distress. Askenasy[5] had similar results when he used the social desirability scale with 156 items from the PERI. Included among these are all 49 items in the long version of the Demoralization Scale.

In our study, we administered Edwards' social desirability scale to a multi-ethnic subset of respondents, using as content the 27 items of the Demoralization Scale. Because inclusion of the social desirability scale considerably lengthened the interview and tended to fatigue both respondent and interviewer, interviewers were asked to administer the social desirability scale only to the first respondent interviewed on a given day. Since the person who was first interviewed depended on many factors, including who was at home on a given day, or what time was most convenient for a given respondent reached by telephone, we have no reason to believe that there was any built-in bias in the assignment procedure.

We administered the social desirability scale in a different way than Dohrenwend and associates did. The interviewer read each item and on a separate sheet of paper the respondent marked one of nine boxes labeled "extremely undesirable" on the left-hand side, "neutral" in the center, and "extremely desirable" on the right-hand side. Our findings run counter to those of Dohrenwend et al. Hispanics tended to rate items more undesirable than blacks or whites. Analysis of their responses indicated that this is due to their greater propensity to mark the first box on the answer sheet, thus artificially lowering their score for each item. Responses to the social desirability scale do not appear to have affected responses to the Demoralization Scale. Among blacks and Hispanics, correlations between responses to a given mental health symptom and responses to its equivalent item in the social desirability scale fluctuate around zero. Among whites, symptomatic responses in a few items correlate (approximately .4) with labelling the trait desirable, but for most scale items, correlations are low.

In sum, we found high reliability of the Demoralization Scale with respect to respondent error, no evidence that acquiescence is a major problem in analyzing the scale, and no evidence of a greater propensity among Hispanics than the other ethnic groups to regard the scale items as being more socially desirable.

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